STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28255

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| ANITA | ELLEN | ADKINS | November 4, 1975 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Sept. 18, 1885 | 90 YRS | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Maryland | United States | | WICOMICO MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Practical Nurse | nursing |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Parsonsburg | YES ☐ NO ☒ | R.D. 1, Mt. Hermon Road |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Joseph | James | Adkins | Catherine | | Holloway |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 217-16-9334 | Mrs. Margie A. Holloway, R.D. 1, Box 39 Parsonsburg, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral Thrombosis | 2 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Senile arteriosclerosis | yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 5/26, 1973, to 11/4, 1975, that (I) (we) last saw the deceased alive on 11/4, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE E. M. Beardsley, MD DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED 11/5/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. E. M. Beardsley

22e. ADDRESS Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | Nov. 7, 1975 | Forest Grove Cemetery | R.D., Parsonsburg, Wic., Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 10 1975 | Marie Jean Martin ACTING REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

12-58522

# DHMH
# DATA ENTRY ROUTE SLIP

Batch Number _____ Serv. Type ____

Payment Month _____ Fisc. Year ____

Amount (If Applicable) _____

Number Documents _____

Date Recv. _____ Date Batched _____

Prepared By _____

Standard Job Name Death-SP

Batch Name/No. De75-7X705

Date Keyed _____

## OPERATOR INFORMATION

| KEY ENTER: | | TIME: | |
|---|---|---|---|
| Oper. 1 | 2042 | Beg 4-16 | End _____ |
| Oper. 2 | _____ | Beg _____ | End _____ |
| Oper. 3 | _____ | Beg _____ | End _____ |
| Oper. 4 | _____ | Beg _____ | End _____ |
| **KEY VERIFY:** | | | |
| Oper. 1 | Steve | Beg 4/16 | End _____ |
| Oper. 2 | _____ | Beg _____ | End _____ |
| Oper. 3 | _____ | Beg _____ | End _____ |
| Oper. 4 | _____ | Beg _____ | End _____ |

DHMH 1205

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28256

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Esther Middle: Lost: ARMWOOD | 2a. DATE OF DEATH Month 11 Day 5 Year 75 | 2b. HOUR 11:50 A M | |
| 3. SEX: F | 4. RACE: Black | 5. DATE OF BIRTH: 12/12/1907 | 6. AGE (In years lost birthday) 67 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Domestic |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Fruitland | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ |
| 13e. STREET AND NUMBER: Rural | | | |
| 14. FATHER'S NAME First: Floyd Middle: Lost: Armwood | 15. MOTHER'S MAIDEN NAME First: Mary Middle: Lost: Maddox | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 219-01-8183 | 17. INFORMANT: Lillian M. Cotton Address: Princess Anne | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few hours
4360
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertensive Crisis — same
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumonia (Serratia)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: — | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): — | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.): — | 21f. LOCATION Street or R.F.D. No. City or Town County State: — | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10-13, 1975, to 11-5, 1975, that (I) (~~we~~) last saw the deceased alive on 11-5-1975, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: G. Galifianakis | M. D. DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11-5-1975 |
| 22d. PHYSICIAN'S NAME (Type): GEORGE GALIFIANAKIS | 22e. ADDRESS | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/8/75 | 23c. NAME OF CEMETERY OR CREMATORY: ST. JAMES | 23d. LOCATION (City or Town) (County) (State): Westover Md. |
| 24. FUNERAL DIRECTOR: Anthony E. Ward Crisfield Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: NOV 13 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin ACTING REGISTRAR |

DHMH-16 1/71 30M (VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28257

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

| | |
|---|---|
| 1. DECEASED-NAME (Type or print) First | JOHN |
| Middle | JAMES |
| Last | AYDELOTTE |
| 2a. DATE OF DEATH Month | NOV |
| Day | 25 |
| Year | 1975 |
| 2b. HOUR | 5:05 AM |
| 3. SEX | MALE |
| 4. RACE | CAUCASIAN |
| 5. DATE OF BIRTH | JAN. 3, 1903 |
| 6. AGE (In years last birthday) | 72 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | |
| IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | MARYLAND |
| 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | DELAWARE |
| 13b. COUNTY | SUSSEX |
| 13c. CITY OR TOWN | SELBYVILLE |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | |
| 13e. STREET AND NUMBER | TRAILER PARK |
| 14. FATHER'S NAME First Middle Last | THOMAS J. AYDELOTTE |
| 15. MOTHER'S MAIDEN NAME First Middle Last | HATTIE FREEMAN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | NO |
| (If yes give war or dates of service) | N/A |
| 16b. SOCIAL SECURITY NO. | 030-09-1123 |
| 17. INFORMANT Address | MRS. HENRIETTA LEWIS SELBYVILLE DEL. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 HOURS
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PROSTATIC HYPERTROPHY REQUIRING SURGERY

| | |
|---|---|
| 19a. DATE OF OPERATION | 11/24/75 |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | URINARY OBSTRUCTION |
| 20a. AUTOPSY? YES ☐ NO ☒ | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | |
| 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | |
| 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 11/12, 19 75, to 11/25, 19 75, that (I) (we) last saw the deceased alive on 11/25 19 75, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | |
|---|---|
| 22b. SIGNATURE | John H. Shenasky II, M.D. |
| DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ |
| 22c. DATE SIGNED | 11/25/75 |
| 22d. PHYSICIAN'S NAME (Type) | JOHN H. SHENASKY II |
| 22e. ADDRESS | 16 MEDICAL CENTER, SALISBURY, MD 21801 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial |
| 23b. DATE | 11/29/75 |
| 23c. NAME OF CEMETERY OR CREMATORY | EVERGREEN |
| 23d. LOCATION (City or Town) (County) (State) | BERLIN Wor MD. |
| 24. FUNERAL DIRECTOR ADDRESS | Anna A. Burbage Berlin Md. |
| 25a. REC'D BY REGISTRAR DATE | DEC 02 1975 |
| 25b. REGISTRAR'S SIGNATURE | Thomas Jan Martin ACTING REGISTRAR |

Item 136 g490 12/1/75 gj

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28258

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST: George Bates Jr. | | | | 2a. DATE OF DEATH MONTH DAY YEAR: November 14, 1975 | 2b. HOUR: 10:45 a.m. M |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH MONTH DAY YEAR: Jan. 19, 1905 | 6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico | | MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Farmer | 12b. KIND OF BUSINESS OR INDUSTRY | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | ~~WORCESTER~~ Wicomico | Salisbury | YES [ ] NO [X] | Rt. 4 |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | | |
|---|---|---|---|
| George Bates Sr. | Mary Smith | | |
| **16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES)** | **16b. SOCIAL SECURITY NO.** | **17. INFORMANT ADDRESS** | |
| No | 225-28-7703 A | Deer's Head Center, Salisbury, Maryland | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

185x

IMMEDIATE CAUSE (a): Adenocarcinoma of prostate with metastasis, — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (in (this hospital) attended the deceased from 10-28-75, 19 75, to 11-14, 19 75, that (I) (we) last saw the deceased alive on 11-14-75, 19 ____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W Maldve, M — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [X] STAFF PHYSICIAN [ ] — 22c. DATE SIGNED: 11-14-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): L. V. Maldve, M.D. — 22e. ADDRESS: Deer's Head Center, Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11 18, 1975 | Mt. Zion Bapt. Cem. | Snow Hill, Wor. Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| New Church, Va. | NOV 20 1975 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/73
(VR A 15(4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28259

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| NOAH | | BIVENS | 11 | 1 | 75 | 6:37 P.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Male | AA | May 7 1907 | 68 YRS. | | | 11-1-75 | 11 M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOMERSET, | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑ | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | 12b. KIND OF BUSINESS OR INDUSTRY |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Wicomico | Fruitland | YES ☑ NO ☐ | Rt 2 Box 205 Princess Anne Md |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| SIDNEY | | BIVENS | MARY | | HARRIS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| UNKNOWN | | 213-12-1567 | ESTELLA COTTOMAN | RT 2 Box 205 P.A. MD |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fracture of cervical spine
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ~~Suddon~~ 30 Mins

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH? | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 6:10 P.M. 11-1-75 | Pedestrian struck by auto. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | street | Rt. 13, Fruitland, Wicomico, Md. |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE _____ M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-3-75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11/8/75 | St Mary Cemetary | Princess Anne Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James Funeral Home, 407 Somerset Ave. Princess Anne, Md. | NOV 13 1975 | Thomas John Marston ACTING REGISTRAR |

75-28259

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28260
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 60M 1/73
(VR A 15 (4))

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Lucy | MIDDLE: Bailey | LAST: Bradley | 2a. DATE OF DEATH MONTH DAY YEAR: November 4, 1975 | 2b. HOUR: 2:20 P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: June 1, 1896 | 6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH: Riverton | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): State Road | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): At Home | 12b. KIND OF BUSINESS OR INDUSTRY: | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Riverton | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: State Road | |
| 14. FATHER'S NAME FIRST: Samuel | MIDDLE: Bailey | LAST: | 15. MOTHER'S MAIDEN NAME FIRST: Nancy | MIDDLE: English | LAST: Bailey |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 215-74-0914 | 17. INFORMANT: Mrs. Inez Dorr | ADDRESS: Riverton, Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Insufficiency due to
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4379
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 19 62, to Nov 4 19 75, that (I) (~~was~~) last saw the deceased alive on May 22 19 75, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~was~~) (~~did~~ (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Thomas C Hill Jr | DEGREE: MD | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 11-7-75 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS C. HILL JR | 22e. ADDRESS: Pine Bluff Road, Salisbury, Md. | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11-7-75 | 23c. NAME OF CEMETERY OR CREMATORY: Riverton Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Riverton, Wicomico, Md. |
| 24. FUNERAL DIRECTOR NAME: Ulrich Funeral Home | ADDRESS: Sharptown, Md. | 25a. DATE REC'D. BY REGISTRAR: NOV 13 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin ACTING REGISTRAR |

75-28260

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28261

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Reta Conaway | Middle | Last: BYRD | 2a. DATE OF DEATH Month: NOVEMBER Day: 12 Year: 1975 | 2b. HOUR: 4:05 P.M. |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: May 11-1901 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico | | Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: None | | |
| 13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Va | 13b. COUNTY: Accomack | 13c. CITY OR TOWN: Hallwood | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: Main Street | |
| 14. FATHER'S NAME First: William T. | Middle | Last: Conaway | 15. MOTHER'S MAIDEN NAME First: Cora | Middle | Last: Butler |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | 16b. SOCIAL SECURITY NO.: 216-74-1253 | (If yes give war or dates of service) | 17. INFORMANT: Mr. Ernest Boyd | Address: Hallwood Va. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO, OR AS A CONSEQUENCE OF
(b): Diabetic arteriolar disease — Undetermined
DUE TO, OR AS A CONSEQUENCE OF
(c): Hypertension — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐ (If either, natify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 11-10-, 1975, to 11-12, 1975, that (I) ~~(we)~~ last saw the deceased alive an 11-12, 1975, and that in (my) ~~(our)~~ opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] M.D. DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11/12/75 | |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11-15-75 | 23c. NAME OF CEMETERY OR CREMATORY: Taylor's | 23d. LOCATION (City or Town): Temperanceville | (County): Accomack (State): Va |
| 24. FUNERAL DIRECTOR: James N. Tat | ADDRESS: Temperanceville Va 23442 | 25a. REC'D BY REGISTRAR DATE: NOV 18 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin ACTING REGISTRAR | |

OHMH-16 1/71 30M
(VR A15 (4))

LA-2826

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28262

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 3DM
(VR A15 (4))

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month | Doy | Yeor | 2b. HOUR |
|---|---|---|---|---|---|---|
| George | D. | Calloway | November | 24 | 1975 | 8:34 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In yeors lost birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| male | white | Sept. 30, 1899 | 76 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | ret. nightwatchman | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Worcester | Willards | | Box 7 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| James | | Calloway | unknown | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| no | 222-01-5959 | Alan Calloway | New Castle, Del. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | M. I. | — |
| Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4/09 | DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD | 10 years |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Mild Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify thot (I) (this hospitol) ottended the deceosed from 1/11, 1972, to 11/24, 1975, thot (I) (we) lost sow the deceosed olive on 10/31 1975, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted obove, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☑ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Gustavo Mestas | | | | | 11/25/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Gustavo A. Mestas | Millsboro Del. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/26/75 | Millsboro Cemetery | Millsboro, Delaware |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Richard T. Watson | Millsboro, Del. | DEC 08 1975 | ACTING REGISTRAR |

75-20202

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28263

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First BROOKS Middle H. Last CAREW
2a. DATE OF DEATH: Month NOVEMBER Day 8 Year 1975
2b. HOUR: 12 P M
3. SEX: M.
4. RACE: White
5. DATE OF BIRTH: May 26 1903
6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MD
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired
12b. KIND OF BUSINESS OR INDUSTRY: Machinist
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: SOMERSET
13c. CITY OR TOWN: Dames Quarter
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: Main Road - RT 363
14. FATHER'S NAME First WALTER Middle Last CAREW
15. MOTHER'S MAIDEN NAME First CORA Middle Last TODD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I
16b. SOCIAL SECURITY NO.: UNKNOWN
17. INFORMANT: BROOKS CAREW JR. Address: 308 MAPLEWAX SALISBURY MD

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Occlusive Coronary artery disease
DUE TO, OR AS A CONSEQUENCE OF (b): Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
4121
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus, Hyperuricemia, Aortic Stenosis, Nephrosclerosis

MEDICAL CERTIFICATION

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☒ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes.
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11-2-75, 19____, to 11-8-75, 19____, thot (I) (we) lost saw the deceased alive on 11-7-75 19____, ond that in (my) (our) opinion deoth occurred on the dote and hour and from the causes stoted obave, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE: B L Agarwal
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 11/10/75
22d. PHYSICIAN'S NAME (Type): BAL K. AGARWAL
22e. ADDRESS: P.G.H - SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: NOV 12-1975
23c. NAME OF CEMETERY OR CREMATORY: Rock Creek Cemetery
23d. LOCATION (City or Town) (County) (State): Crisfield Som MD
24. FUNERAL DIRECTOR: Leroy Webster ADDRESS: Princess Anne MD 21853
25a. REC'D BY REGISTRAR DATE: NOV 17 1975
25b. REGISTRAR'S SIGNATURE: Thomas James Martin ACTING REGISTRAR

DHMH-16 1/71 30M
(VR A15 (4))

15-28253

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

75-28264

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last: Hattie M. Carmean | 2a. DATE OF DEATH Month Day Year: November 1, 1975 | 2b. HOUR: 5P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: August 27, 1890 | 6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First Middle Last: Sanford D. Mathews | 15. MOTHER'S MAIDEN NAME First Middle Last: Maggie Jane Guthrie | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No | 16b. SOCIAL SECURITY NO.: 213742057 | 17. INFORMANT Address: Douglas M. Carmean, Snow Hill, Md. | |

90
35
230
2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | MYOCARDIAL FAILURE | 24 HOURS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HYPERTENSION | MANY YEARS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | ARTERIOSCLEROTIC HEART DISEASE | MANY YEARS |

4121

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PROBABLE CARCINOMA OF NECK

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

2
X

22a. I certify that (I) (~~this hospital~~) attended the deceased from OCTOBER, 1975, to OCT. 28TH, 1975, that (I) (~~we~~) last saw the deceased alive on OCT. 28TH 1975, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Dorothy C. Holzworth M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11-1-75 | |
| 22d. PHYSICIAN'S NAME (Type): DOROTHY C. HOLZWORTH | 22e. ADDRESS: 104 BAY ST. SNOW HILL, MD. | |

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11-4-75 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Bates Meth. | 23d. LOCATION (City or Town) (County) (State): Snow Hill, Maryland |
| 24. FUNERAL DIRECTOR: Herman L. Kennis | ADDRESS: Snow Hill, Md. | 25a. REC'D BY REGISTRAR DATE: NOV 12 1975 | 25b. REGISTRAR'S SIGNATURE: Frances Jane Martin ACTING REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 23m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28265

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR |
|---|---|---|---|---|
| Maggie | | CLARK | 11-4-75 | 5:10 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | January 28, 1882 | 93 YRS. | | |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. NEVER MARRIED / WIDOWED / DIVORCED | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| U.S. (Unknown) | United States | NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | Wicomico MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Deer's Head Center | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Kent | Betterton | YES ☒ NO ☐ | NONE |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| JOHN | Z. | CLARK | ROSINE | C. | GATES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | — | UNKNOWN 213-14-1840 | Deer's Head Center Records | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral Thrombosis a Hemiplegia L. | yrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerosis of Cardiovascular D. | yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from August 21, 19 69, to November 4, 19 75, that (I) (we) last saw the deceased alive on November 4, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Lee L Lawry, M.D. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 11-4-75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Lee L. Lawry, M.D. | Deer's Head Center Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11-8-75 | CHESTER CEMTY | CHESTERTOWN KENT MD. |

| 24. FUNERAL DIRECTOR NAME | ADDRESS | 25a. DATE REC'D. BY REGISTRAR | REGISTRAR'S SIGNATURE |
|---|---|---|---|
| VICTOR N. KENNEDY | STILL POND, MD. | NOV 7 1975 | Mamie Jane Hamilton ACTING REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

75-28265

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28266

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: THELMA | Middle: | Last: COUSINS | 2a. DATE OF DEATH Month: November Day: 1 Year: 1975 | 2b. HOUR: 5:57 M |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: Nov. 15, 1910 | 6. AGE (In years last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Retired | | |
| 13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE: Virginia | 13b. COUNTY: Northampton, Eastville | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: R.F.D. BOX 171-K Cape Charles, Va. | |
| 14. FATHER'S NAME First: Charles | Middle: Upshur | Last: | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Weston | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 224-20-2099 | 17. INFORMANT: George Cousins | Address: R.F.D. Box 171-K Cape Charles Va. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tuberculous meningitis
DUE TO, OR AS A CONSEQUENCE OF (b): e Hydrocephalus
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Oct - Nov

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify thot (I) (this hospital) attended the deceased from 10-15, 1975, to 11-1, 1975, that (I) (we) lost saw the deceased alive an 10-31, 1975, and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. Shoemaker DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): H. Shoemaker

22e. ADDRESS: Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Nov. 9, 1975 | 23c. NAME OF CEMETERY OR CREMATORY: Union Bapt. Church Cem. | 23d. LOCATION (City or Town): Eastville | (County): Northampton Co. (State): Va. |
| 24. FUNERAL DIRECTOR: Alston D. Godwin | ADDRESS: 625 Madison Ave, Cape Charles, Va. | 25a. REC'D BY REGISTRAR DATE: NOV 10 1975 | 25b. REGISTRAR'S SIGNATURE: ACTING REGISTRAR | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

75-28267

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ROSIE | PEARL | DENNIS | 11 16 75 | 1:10 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | BLACK | 7-26-1899 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | NEVER MARRIED [X] | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| SALISBURY | Salisbury Nursing Home | Housework | Domestic |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salis bury | YES [ ] NO [X] | 723 Dennis Street |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Clayton Allen | Parker | | Mary | Emma | Farlow |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 219-07-7797 | Mrs. Florence Selby, Laurel, Delawar |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of the lung & cerebral metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediote couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING [ ] / UNDERLYING CAUSE OF DEATH [ ] (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 11/10, 19 75, to 11/16, 19 75, that (I) (~~we~~) last saw the deceased alive on 11/15, 19 75, and that in (my) (~~our~~) opinian death accured on the date and haur and from the causes stated obave, (I) (~~we~~) (did) (did not) view the body after deoth.

22b. SIGNATURE Earl M. Beardsley M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED 11/17/75

22d. PHYSICIAN'S NAME (Type) EARL M. BEARDSLEY, M.D.

22e. ADDRESS 2180 U.S.50 at Civic Ave, Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11-21-75 | Glass Hill | Parsonsburg-Wicomico- Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| West Funeral Home, Salisbury, Md. | NOV 20 1975 | ACTING REGISTRAR |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

MRA 15 (4) 25m-1/70

M

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

75-28268

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Mary | Catherine | Dukes | Nov. | 4 | 1975 | 7:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| Female | White | July 27, 1897 | 78 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | Housekeeper | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Worcester | Girdletree | | No Street Name |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | Coakman | Dukes | Sallie | Lydia | Truitt |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | — | 216182027 | Ralph E. Shockley | Snow Hill Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Medical Hospital

DUE TO, OR AS A CONSEQUENCE OF (b) Senile Deterioration

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) Unk (b) Yrs (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended ~~the deceased from~~ 8/11, 1975, to 11/4, 1975, that (I) (we) last saw the deceased alive on 11/3, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Shockley MD | | ☑ | ☐ | ☐ | 11/5/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Earl M. Beardsley, M.D. | U.S. 50 at Civic Ave. Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR ~~CREMATORY~~ | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11-7-75 | Whitecoat Meth. | Snow Hill Md. Worcester |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Truman E. Nelms | Snow Hill, Md. | NOV 12 1975 | ACTING REGISTRAR |

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 75-28269

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ MONTH DAY YEAR | 2b. HOUR |
| BESSIE | V. | EIFERT | Nov. 25 1975 | 2 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
| Female | White | 7/22/1907 | 68 YRS. | | | November 25 1975 | 7:35 2 AM |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | United States | | WICOMICO MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury | 206 Walston Avenue | Telephone Operator | Answering Serv. |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☐ | 206 Walston Avenue |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Sylvester | | Muir | Sadie | | Sydnor |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (daughter) ADDRESS |
|---|---|---|---|
| No | | 180-26-1731 | Mrs. Jill Barbon, Ocean City, Maryland |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE Earl L. Royer M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11/25/75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| Burial | 11/28/75 | Oriole Cemetery | Oriole, Somerset, Maryland |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | DEC 01 1975 | Frances Jan Martin ACTING REGISTRAR |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, RELEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH 17
(VR A15 ME(5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28270

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

M

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ABRAHAM | ---- | Esses | November 9 1975 | 7:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | January 7, 1927 | 48 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| New York | United States | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| 80 Salisbury, Md. | Peninsula General Hsp. | Proprietor | Dept. Store |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| 35 Maryland | Worcester | Ocean City | YES [ ] NO [ ] | 135B California Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| 230 Isaac | | Esses | Sarah | | (unknown) |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| 2 Yes | WW II | 111-18-9268 | Mrs. Abraham Esses (Wife) | same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiogenic Shock — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINS
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarctum — HRS
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovas. Disease — YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertriglyceridemia

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| X | | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/9, 19 75, to 11/9, 19 75, that (I) (we) lost saw the deceased alive on 11/9 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Donald M. Wood MD | | [X] | [ ] | [ ] | 11/9/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| 1 Donald M. Wood, M | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/11/75 | Beth Israel Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 12 1975 | Mamie Jean Parker ACTING REGISTRAR |

Item 7b g490 12/2/75 gj

1 - FOR STATE REGISTRAR

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

REG. NO. 75-28271

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Leroy | MIDDLE: H. | LAST: FISKE | 2a. DATE OF DEATH MONTH: November | DAY: 11 | YEAR: 75 |
| 2b. HOUR: 6 P M | | | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH: June | DAY: 17 | YEAR: 1898 | |
| 6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico | | MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Clothing | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Queen Anne | Centreville | YES ☒ NO ☐ | Chesterfields Avenue |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Unknown | Unknown |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Unknown | | 156-16-9126A | Deer's Head Center Records-Salisbury, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease — years

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify thot (I) (this hospitol) attended the deceased from October 15, 19 75, to November 11, 19 75, thot (I) (we) lost sow the deceased olive on November 11, 19 75, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body otter deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ | 22c. DATE SIGNED |
|---|---|---|---|
| H. Wilberg | MD | | 11-11-75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Harald M. Wilberg, M.D. | Deer's Head Center, Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11-15-75 | Hillcrest Cem. | Federalsburg, Talbot, Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Helfenbein-Hubbard Successor To: Lane Funeral Home, Chester, Md. 21619 | NOV 18 1975 | Thomas Jean Matthew REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

75-28271

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28272

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 IV 71 30M (VR A15 (4))

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Catherine | Middle: Mary | Last: FLYNN | 2a. DATE OF DEATH Month: NOVEMBER | Day: 18 | Year: 1975 |
| 2b. HOUR: 1:45 PM | | | | | | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: September 14, 1898 | 6. AGE (In years last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): New Jersey | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Office Manager | 12b. KIND OF BUSINESS OR INDUSTRY: Civil Serv. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: R.D. 1, Ogle Ave. | | |
| 14. FATHER'S NAME First: Patrick | Middle: Joseph | Last: Flynn | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: Ann | Last: Foster | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes give war or dates of service): WW II | 16b. SOCIAL SECURITY NO.: 094-07-1967A | 17. INFORMANT (Brother) Address: Mr. David P. Flynn, Jersey City, N. J. | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 days
DUE TO, OR AS A CONSEQUENCE OF
(b): ASHD
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Breast cancer metastatic to lung

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this haspitol) attended the deceased fram _____, 19____, to _____, 19____, thot (I) (we) lost sow the deceosed olive an _____ 19____, and thot in (my) (our) opinian deoth occurred on the dote and haur and fram the couses stated above, (I) (we) (did) (did not) view the bady after deoth.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Alberta Mattax Polin DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11-18-75 | |
| 22d. PHYSICIAN'S NAME (Type): Dr. Alberta Mattax Polin | 22e. ADDRESS: Salisbury, Maryland | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/21/75 | 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. REC'D BY REGISTRAR DATE: NOV 24 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jan Matthew ACTING REGISTRAR | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28273
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ELLEN — MIDDLE: Mc CARTHY — LAST: FOLEY

2a. DATE OF DEATH — MONTH: NOV. — DAY: 24 — YEAR: 1975

2b. HOUR: 3:00 PM

3. SEX: F

4. RACE: CAUC.

5. DATE OF BIRTH — MONTH: JAN — DAY: 23 — YEAR: 1882

6. AGE (IN YEARS LAST BIRTHDAY): 93 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): BREESEPORT N.Y.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD

10. CITY OR TOWN OF DEATH: SALISBURY

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): TEACHER

12b. KIND OF BUSINESS OR INDUSTRY: RETIRED

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: MARYLAND

13b. COUNTY: WOR

13c. CITY OR TOWN: BERLIN

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET ADDRESS: MAPLE AVE.

14. FATHER'S NAME — FIRST: JOHN — MIDDLE: HENRY — LAST: McCARTHY

15. MOTHER'S MAIDEN NAME — FIRST: NANCY — MIDDLE: — LAST: TAYLOR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO

(IF YES, GIVE WAR OR DATES): NO

16b. SOCIAL SECURITY NO.: 212-74-3056

17. INFORMANT — ADDRESS: J. WARNER FOLEY MAPLE AVE, BERLIN MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1wk.

DUE TO, OR AS A CONSEQUENCE OF (b): generalized arteriosclerosis — 4yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 11/22, 19 72 to 11/24, 19 75 that (I) (we) last saw the deceased alive on 11/25, 19 75 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Earle Bradley DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 11/25/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): EARL M. BRADSLEY

22e. ADDRESS: 425 PINEHURST AVE. SALISBURY, MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 11/29/75

23c. NAME OF CEMETERY OR CREMATORY: BROOKSIDE

23d. LOCATION — CITY OR TOWN: ENGLEWOOD — COUNTY — STATE: N.J.

24. FUNERAL DIRECTOR — NAME: Anna A. Burbage — ADDRESS: Berlin Md

25a. DATE REC'D. BY REGISTRAR: DEC 02 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jan Marthen — ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP____

DHMH - 1660M 1/75
(VR A 15 (4))

Items 21a-21i Film 49
12/10/75 mh

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-28274

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| Helen | Violet | Foxwell |

2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month NOV. Day 26 Year 1975 — 2b. HOUR 2:45 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| Female | White | Sept. 27, 1902 | 73 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month NOVEMBER Day 26 Year 1975 — 2d. HOUR 2:45 P.M.

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Nebraska | United States | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Asst. Librarian | Hospital |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☐ | Box 310, Cdmean Ave. Extd. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Benjamin | F. | Beard | Bertha | | Lass |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | | Mr. Willie B. Foxwell (Husband) same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Fractured Skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 2:45 P.M. 11 28 75 | Auto Accident |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | 60 Ft.Rd.&Rt.346 | | Pittsville | Wic. | Md. |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Philip A Insley Sr M.D.

EXAMINER'S NAME (Type) Philip A. Insley Sr M/I

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED 11-26-75

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/29/75 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | DEC 01 1975 | Frances Jan Hutchison ACTING REGISTRAR |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMI. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

75-28274

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28275

1

M

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Walter | Matthew | Futrell | November 22 1975 | 5:45 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (If years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| M | Negro | 7-20-09 | 66 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| N.C. | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Retired | Laborer |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Quantico | YES ☐ NO ☒ | Rt #1 Box 191 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Walter | M. | Futrell | Sallie | | Lassit |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| | | | Vera Futrell | (SAME AS Above) |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | cerebral hemorrhage | 9 hrs |
| DUE TO, OR AS A CONSEQUENCE OF (b) | cerebral arteriosclerosis | 4 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4319

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-22, 19 75, to 11-23, 19 75, that (I) (we) last saw the deceased alive on 11-23 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John S. Buckley | MD | | | | 11-23-75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11-27-75 | GREEN ACRES | SALISBURY Wico. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Jolley Memorial Chapel | Salisbury, Md. | DEC 01 1975 | Thomas Jan Marston ACTING REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28276

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | CLARENCE | Middle JOSEPH | Last Gould |
| 2a. DATE OF DEATH Month Day Year | November 4 1975 | 2b. HOUR | 12:59 PM |
| 3. SEX | Male | | |
| 4. RACE | White | | |
| 5. DATE OF BIRTH | Feb. 3, 1907 | | |
| 6. AGE (In years last birthday) | 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | United States | | |
| 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | | |
| 9. COUNTY OF DEATH | Wicomico Md | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hospital | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Retired Salesman | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Electrical Supply | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | | |
| 13b. COUNTY | Wicomico | | |
| 13c. CITY OR TOWN | Salisbury | | |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | | | |
| 13e. STREET AND NUMBER | 1011 Bell Avenue | | |
| 14. FATHER'S NAME First | Frank | Middle | Last Gould |
| 15. MOTHER'S MAIDEN NAME First | Florence | Middle | Last (unknown) |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | Yes | (If yes give war or dates of service) WW II | |
| 16b. SOCIAL SECURITY NO. | 213-03-5413 | | |
| 17. INFORMANT Address | Mrs. Anna A. Gould (wife) same as 13 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic cancer
DUE TO, OR AS A CONSEQUENCE OF (c) Renal shutdown
4440
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertensive bypass

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 10/30/75 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | Leriche syndrome |
| 20a. AUTOPSY? YES ☐ NO ☐ | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/28, 1975, to 11/4, 1975, that (I) (we) last saw the deceased alive on 11/4 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Richard E. Hughes | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 11/4/75 |
| 22d. PHYSICIAN'S NAME (Type) | Dr. Richard E. Hughes | 22e. ADDRESS | Medical Center, Salisbury, Md. |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | 11/7/75 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Wicomico Memorial Park | 23d. LOCATION (City or Town) (County) (State) | Salisbury, Wicomico Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS | HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. REC'D BY REGISTRAR DATE | NOV 10 1975 | 25b. REGISTRAR'S SIGNATURE ACTING REGISTRAR |

DHMH-16 1/71 30M
(VR A15 (4))

75-28216

M

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28277

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 (VR A15 (4))

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Dewey | Middle | Brice | Last | GRAY | 2a. DATE OF DEATH Month | NOVEMBER |
| Day | 4 | Year | 1975 | 2b. HOUR | 1P | M | |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH | Jan. 12, 1898 | 6. AGE (In years last Birthday) | 77 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | Md. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH | Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Ret. Waterman | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Md. | 13b. COUNTY | Dor. | 13c. CITY OR TOWN | Elliott | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER P.O. Box |
| 14. FATHER'S NAME First | Cornelius | Middle | | Last | Gray | 15. MOTHER'S MAIDEN NAME First | Susan |
| Middle | | Last | Gray | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | 218-24-2599 | 17. INFORMANT | C. Nelton Gray | Address | 111 Williams St Salisbury, Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Renal Diseases — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
404X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Parkinsons Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| X | | | |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| X | | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 10-25, 1975, to 11-4, 1975, that (I) (we) last saw the deceased alive on 11-4-1975 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Phillip A Insley | DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type) | Ph. L. A Insley | 22e. ADDRESS | Salisbury Md |
| 1 | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | Nov. 7, 1975 | 23c. NAME OF CEMETERY OR CREMATORY: Elliott |
| 23d. LOCATION (City or Town) | Elliott | (County) | Dor. | (State) Md. |
| 24. FUNERAL DIRECTOR | Ruth S. Hollingsworth | ADDRESS | East New Market, Md. | 25a. REC'D BY REGISTRAR DATE NOV 6 1975 |
| 25b. REGISTRAR'S SIGNATURE | Thomas J. [illegible] ACTING REGISTRAR | | | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| DARYL | ELDON | Hake | November 9 1975 | 9:29 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | October 24, 1919 | 56 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Iowa | United States | | Wicomico Md |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Security | USAF |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES X NO ☐ | 206 S. Haven Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Frank | | Hake | Jennie | Agnes | Pierce |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| Yes | Korean | 480-18-8709 | Mrs. Goldie A. Hake (wife) same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of Liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 5-3-73, 19___, to 11-9-75, 19___, thot (I) (we) last saw the deceased alive on 11-8-75 19___, and that in (my) (aur) opinion death occurred an the dote and hour and fram the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 11/20/75

22d. PHYSICIAN'S NAME (Type) Earl L. Royer, M.D. — 22e. ADDRESS 409 Camden Ave., Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/12/75 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 13 1975 | Mary Jean Norton ASSIST. REGISTRAR |

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 75-28279

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH DAY YEAR | 2b. HOUR |
| RUSSELL | WILLIAM | HALL, SR. | 11-6-75 | 7:35 A M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR If |
| M | W | 12 8 05 | 69 YRS. | | | 11-6-75 19 | M |

| | | | |
|---|---|---|---|
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
| Maryland | U.S. | | Wicomico MD. |

| | | | |
|---|---|---|---|
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury | DOA Peninsula General | State Road Employee | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS |
| Md. | Somerset | Oriole | | Rt. 627 |

| | | | | | |
|---|---|---|---|---|---|
| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
| E. | James | Hall, Sr. | Ella | | Noble |

| | | | |
|---|---|---|---|
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
| no | 213-22-7464 | Russell W. Hall, Jr. | Oriole, Md. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| | | |

| | | |
|---|---|---|
| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐,

ACTUAL SIGNATURE [signature] TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 11-7-75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
| Burial | 11/8/75 | Oriole Cemetery | Oriole, Somerset, Md. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| Hinman Funeral Home, Somerset Ave. Princess Anne, Md. | NOV 10 1975 | [signature] ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73
(VR A15 ME (5))

75-20279

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28280

1

M

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HORACE | Middle: S. | Last: Hamblin | 2a. DATE OF DEATH Month: November | Day: 21 | Year: 1975 |
| 2b. HOUR: 9:20 PM | | | | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: DEC 3, 1898 | 6. AGE (In years last birthday): 76 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RET. MAINTENCE | 12b. KIND OF BUSINESS OR INDUSTRY: GOLF COURSE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: MARYLAND | 13b. COUNTY: WORCESTER | 13c. CITY OR TOWN: WHALEYVILLE | 13d. INSIDE CITY LIMITS? NO ☒ | 13e. STREET AND NUMBER: R.F.D. | | |
| 14. FATHER'S NAME First: THOMAS | Middle: HAMBLIN | Last | 15. MOTHER'S MAIDEN NAME First: LAURA | Middle: DAVIS | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES | (If yes, give war or dates of service): WORLD WAR #1 | 16b. SOCIAL SECURITY NO.: 211-10-3720 | 17. INFORMANT: MATTIE HAMBLIN | Address: WHALEYVILLE, MD. | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occ
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| UNDERLYING ☐ | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11-15, 19 25, to 11-24, 19 25, that (I) (we) last saw the deceased alive on 11-24 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|
| | | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Nevins W. Todd, M.D. | Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11-23-75 | EVERGREEN | BERLIN WORCESTER, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Peter Whaley | Selbyville, Del | DEC 01 1975 | ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene priar to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28281

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| J. | CLIFTON | HASTINGS | NOVEMBER 26 1975 | 12 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | OCT. 9, 1905 | 70 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | BANK CASHIER | BANK |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| DELAWARE | SUSSEX | SELBYVILLE | YES ☒ NO ☐ | FENWICK ROAD |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ORLANDO | | HASTINGS | LINA | | HUDSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| X | X | 221-09-7348 | ELIZABETH HASTINGS | SELBYVILLE DEL |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4319
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/25, 19 75, to 11/25 19 75, that (I) (we) last saw the deceased alive on 11/25 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Helen M. Baldado | M.D. | ☒ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11-29-75 | ODD FELLOWS | BISHOPVILLE WORCESTER Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Peter Wheatley | Selbyville Del. | DEC 01 1975 | Thomas Jan Murphy ACTING REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16-1/71-30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

75-28282

1

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR | | |
| Bessie | N. | Hayman | November 27 1975 | 4:20 A M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | |
| Female | White | April 30, 1882 | 93 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH | | | |
| Maryland | USA | | Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 90 Salisbury | Salisbury Nursing Home | Housewife | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | |
| 35 Maryland | Worcester | Snow Hill | YES ☑ NO ☐ | 100 S. Washington St. | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | |
| 230 George | W. | Nicholson | Mary | Ann | Dickenson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | |
| 2 No | | 212744632 | Ella H. Sturgis | Snow Hill, Md. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiac thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Pak.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — 4yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | YES ☐ NO ☐ | |

| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| X | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 11/24, 1975, to 11/27, 1975, that (I) (we) last saw the deceased alive on 11/26 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Earl M. Beardsley M.D. | MD | ☑ | ☐ | ☐ | 11/28/75 |
| 1 22d. PHYSICIAN'S NAME (Type) Earl M. Beardsley, M.D. | | 22e. ADDRESS 21801 U.S. 50 at Civic Ave., Salisbury, Md. | | | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11-29-75 | Whatcoat Meth. | Snow Hill, Md. |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
| Truman Fuhrman | Snow Hill, Md. | DEC 03 1975 | Thomas Jean Martin ASSTNT. REGISTRAR |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28283
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Records must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| EDNA | PEARL | HAYMAN | November 6 1975 | 7:15 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN |
| Female | White | December 2, 1900 | 74 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Delaware | United States | | Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury, Md. | Peninsula General Hosp. | | Housewife | none | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES [ ] NO [ ] | 1113 Riverside Drive |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Magruder | | Morris | Anna | | Pusey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 214-74-2515 | Mr. B. Lee Hayman (Husband) same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Extravasation of | 2 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma Rt colon | chronic |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19 75 to [illegible] 19 75, that (I) (we) last saw the deceased alive on [illegible] 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] MD | ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 11/7/75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. David P. Largey | Medical Center, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/8/75 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 10 1975 | [signature] ACTING REGISTRAR |

DHMH-1660M/1/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28284

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 3DM
(VR A15 (4))

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: MADELINE | Middle: | Last: Heath | 2a. DATE OF DEATH Month: November Day: 8 Year: 1975 | 2b. HOUR: 10 P.M. | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: April 10, 1902 | 6. AGE (In years last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): M.D. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Delmar | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Box 214 | |
| 14. FATHER'S NAME First: George | Middle: E. | Last: Dorsey | 15. MOTHER'S MAIDEN NAME First: Lettie | Middle: | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service): — | 16b. SOCIAL SECURITY NO.: 220-03-8698 | 17. INFORMANT: Gilbert Heath | Address: Box 214 Delmar Md. 21840 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic Heart Disease
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse lost.
4123
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS (If either, notify medicol examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Oct 11, 19 25, to Oct 25, 19 25, that (I) (~~we~~) last saw the deceased alive on Oct 25 19 25, and thot in (my) (~~our~~) opinion death accurred on the dote ond hour ond from the couses stated above, (I) (~~we~~) (~~did~~) (did nat) view the bady ofter death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Thomas C Hall Jr | M.D. DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: Nov. 10, 1975 |
| 22d. PHYSICIAN'S NAME (Type): | 22e. ADDRESS: Pris Bluff Road Salisbury Md | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/12/1975 | 23c. NAME OF CEMETERY OR CREMATORY: Wico Mem. Park | 23d. LOCATION (City or Town): Salisbury | (County): (State): Md. |
| 24. FUNERAL DIRECTOR: Hill-Baker-Bounds | ADDRESS: Salisbury Md | 25a. REC'D BY REGISTRAR DATE: NOV 13 1975 | 25b. REGISTRAR'S SIGNATURE: Anne Jean Austin | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28285

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: John MIDDLE: LAST: Heller | | | 2a. DATE OF DEATH MONTH DAY YEAR: Nov. 11, 1975 | 2b. HOUR: 7:05AM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Nov 13, 1886 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 yrs. YRS. IF UNDER 1 YEAR MONTHS: DAYS: | HOURS: MIN.: |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): State Highway Dept. | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Delaware | 13b. COUNTY: Sussex | 13c. CITY OR TOWN: Fenwick Island | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: Box 298 D. - R.D. 1 |
| 14. FATHER'S NAME FIRST: William MIDDLE: LAST: Heller | | | 15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: LAST: Swain | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO (IF YES, GIVE WAR OR DATES): | | 16b. SOCIAL SECURITY NO.: 222-10-6452 | 17. INFORMANT: Mrs. John Heller | ADDRESS: Fenwick Island |

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 hr.

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

X

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/9/75 to 11/11/75, that (I) (we) last saw the deceased alive on 11/10/75 and that in my (our) opinion death occurred at the date and hour and from the causes stated above. (Type (Print) and not view the body after death.

22b. SIGNATURE: E. M. Beardsley DEGREE: M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/11/75

1

22d. PHYSICIAN'S NAME (TYPE OR PRINT): E. M. Beardsley M. D. — 22e. ADDRESS: Civic Ave. Salis. Md. 21801

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/14/75 | 23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows Cem | 23d. LOCATION CITY OR TOWN: Smyrna | COUNTY: Kent STATE: Del. |
| 24. FUNERAL DIRECTOR NAME: Robert C. Hutchison | ADDRESS: Middletown, Del. | 25a. DATE REC'D. BY REGISTRAR: NOV 14 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jan Marbin ACTING REGISTRAR | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15(4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR 1- STATE REGISTRAR

REG. NO. 75-28286

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ARTHUR | MIDDLE: PLUMMER | LAST: HILGHMAN | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒ MONTH DAY YEAR: 11-14-75 | 2b. HOUR: 10P M | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: 2 4 01 | 6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR: 11-15-75 | 2d. HOUR: 9:30 A M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Hebron | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 103 Grove St. | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Wicomico | Hebron | YES ☐ NO ☐ | 103 Grove St. |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| GEORGE HILGHMAN | ELIZABETH BROMLEY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) / (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO. | | MRS HILDA GRALF. BRIDGEVILLE, DEL. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

4109

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

Pulmonary Emphysema.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE: Earl L. Royer — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 11-17-75

EXAMINER'S NAME (TYPE OR PRINT): Earl L. Royer, M.D. — ADDRESS: 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIL | II/I8/I975 | HEBRON CEMETERY | HEBRON, MD. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Wilson Funeral Home, Salisbury, Md. | NOV 24 1975 | Thomas Jan Northen ACTING REGISTRAR |

DHMH-17 20M 1/73
(VR A15 ME (5))

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

75-28208

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28287
REG. NO.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Frances; MIDDLE: E.; LAST: HITCHENS | | 2a. DATE OF DEATH MONTH DAY YEAR: Nov. 21 1975 | 2b. HOUR: 3:10 pM |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: June 10 1887 | 6. AGE (IN YEARS LAST BIRTHDAY): 88 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wor Co. Md | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Sales Lady | 12b. KIND OF BUSINESS OR INDUSTRY: |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Pocomoke | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 903 Second Street |
| 14. FATHER'S NAME FIRST: Isaac; MIDDLE: W; LAST: Hitchens | | 15. MOTHER'S MAIDEN NAME FIRST: Emma; MIDDLE: Landing; LAST: Hitchens | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Unknown (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 219-05-8717 A | 17. INFORMANT ADDRESS: Deer's Head Center Records-Salisbury, Md. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease — long standing
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): fractured pelvis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 4, 19 75, to Nov. 21, 19 75, that (I) (we) last saw the deceased alive on Nov. 21, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H. Wilberg MD DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 11-21-75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Harald M. Wilberg, M.D. — 22e. ADDRESS: Deer's Head Center, Salisbury, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 24 Nov 1975 | 23c. NAME OF CEMETERY OR CREMATORY: Forrest Lawn Cem | 23d. LOCATION CITY OR TOWN: Norfolk | COUNTY STATE: VA. |
| 24. FUNERAL DIRECTOR NAME: Scott S Melson | ADDRESS: Pocomoke City, Md | 25a. DATE REC'D. BY REGISTRAR: NOV 25 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jean Northam | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 thru 3 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28288

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M
(VR A 15 (4) ) 9/74

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: MARTHA | MIDDLE: CARROLL | LAST: HOFFMAN | 2a. DATE OF DEATH MONTH DAY YEAR: November 28, 1975 | 2b. HOUR: M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: May 15, 1881 | 6. AGE (IN YEARS LAST BIRTHDAY): 94 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD. | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housework | 12b. KIND OF BUSINESS OR INDUSTRY: at home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 117 Davis Street |
| 14. FATHER'S NAME FIRST: Thomas MIDDLE: James LAST: Whayland | | 15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: Jane LAST: Ackworth | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 202-05-6963D | 17. INFORMANT: (Daughter) | ADDRESS: 734 S. Park Drive Mrs. Carrie Mears, Salisbury, Maryland | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 wk.
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — 4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/17/74 to 11/28/75, that (I) (we) last saw the deceased alive on 11/28/75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sally Beardsley — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/29/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. E. M. Beardsley — 22e. ADDRESS: Salisbury, Maryland

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/1/75 | 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | 23d. LOCATION CITY OR TOWN COUNTY STATE: Salisbury, Wicomico, Maryland |
| 24. FUNERAL DIRECTOR NAME ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR: DEC 04 1975 | 25b. REGISTRAR'S SIGNATURE: Frances Jean Martin ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28289

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LUCINDA MIDDLE: JULIA LAST: HUDSON | | | 2a. DATE OF DEATH MONTH DAY YEAR: November 13, 1975 — 2b. HOUR: M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 19, 1890 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Delaware | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Seamstress — 12b. KIND OF BUSINESS OR INDUSTRY: clothing |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET ADDRESS: 413 Barclay Street |
| 14. FATHER'S NAME FIRST: George MIDDLE: Edward LAST: Hudson | | 15. MOTHER'S MAIDEN NAME FIRST: Lavenia MIDDLE: LAST: Shockley | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 219-05-8391A | 17. INFORMANT (Daughter) ADDRESS: 425 Prince St. Mrs. Lena Smullen, Salisbury, Maryland | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Take
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yrs.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 9/24/74, 19 — to 11/13, 19 75, that (I) (we) last saw the deceased alive on 11/13, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/14/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. E. M. Beardsley — 22e. ADDRESS: Salisbury, Maryland

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/17/75 | 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Salisbury, Wicomico, Maryland |
| 24. FUNERAL DIRECTOR NAME / ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. DATE REC'D. BY REGISTRAR: NOV 19 1975 | 25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

75-28285

Items #5,6 filmg 490 12/18/75 cr

# STATE OF MARYLAND
# DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

75-28290

1

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Arintha | Middle: | Last: Heath | 2a. DATE OF DEATH Month: NOVEMBER Day: 22 Year: 1975 | 2b. HOUR: 3:03 P.M. | | |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: May 12, 1913 | 6. AGE (In years last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | | |
| 7a. BIRTHPLACE (State or foreign country): Somerset | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH: Wicomico Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Home wife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Wic | 13c. CITY OR TOWN: Wic Forest | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME First: John | Middle: | Last: Fields | 15. MOTHER'S MAIDEN NAME First: Mary | Middle: | Last: Spence | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-14-3559 | 17. INFORMANT: Alice Moore | Address: New York City | | | |

80 35 220 1

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF (b): Brain metastasis, Primary.

DUE TO, OR AS A CONSEQUENCE OF (c): Gastric Carcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1519

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

2

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

X

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from 11/14/75, 19____, to Nov. 22, 19 75, that (I) (we) last saw the deceased alive on Nov. 22 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Helen M. Baldado | M.D. | ☒ | ☐ | ☐ | |

1

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | 11/28/75 | Wicomico Memorial Gdns | Wicomico Co. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James Funeral Home | Rt 3 Box 284 Princess Anne Md. | DEC 05 1975 | ACTING REGISTRAR |

100

DHMH-16 1/71 30M
(VR A15 (4))

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 13a-e filmg490 12/19/75sx

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28291

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: George | MIDDLE: E | LAST: Johnson | 2a. DATE OF DEATH MONTH DAY YEAR: 11-29-75 | 2b. HOUR: 5 P.M. | |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH MONTH DAY YEAR: Feb. 22 1914 | 6. AGE (IN YEARS LAST BIRTHDAY): 61 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico | MD. | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Health Care Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: Mill | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE: Md. | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET ADDRESS: 203 Cypress Lane |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME FIRST: Lemuel | MIDDLE: | LAST: Johnson | 15. MOTHER'S MAIDEN NAME FIRST: Cora MIDDLE: LAST: Selby |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES): | 16b. SOCIAL SECURITY NO.: 218-12-1859 | 17. INFORMANT: Willie Johnson ADDRESS: |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | metastatic carcinoma | 4 mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) | adenocarcinoma stomach | 4 mos |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1519
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hypertension, Diabetes

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |

22a. I certify that (I) (this hospital) attended the deceased from 10-10 19 75, to 11-29 19 75, that (I) (we) last saw the deceased alive on 11-29 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John T. Bulkeley | DEGREE: M.D. | ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 22c. DATE SIGNED: 11-29-75 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): John T. Bulkeley, M.D. | 22e. ADDRESS: Pine Bluff Rd., & Salisbury Blvd. Salisbury, Md. | | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12-4-75 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Wesley Cem. | 23d. LOCATION CITY OR TOWN: Snow Hill | COUNTY: Wor. | STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Wm. J. Lawrence | ADDRESS: New Church, Va. | 25. DATE REC'D. BY REGISTRAR: DEC 08 1975 | 26. REGISTRAR'S SIGNATURE: Thomas Jean Matthews ACTING REGISTRAR | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 1660M 1/75
(VR A 15 (4))

# STATE OF MARYLAND
# DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

75-28292

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 / 771 30M
(VR A15 (4))

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: DAVID | Middle: HORMAN | Last: JONES Jr. | 2a. DATE OF DEATH Month: November Day: 1 Year: 1975 | 2b. HOUR: 4:20 A.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: OCT 14, 1910 | 6. AGE (In years last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.of A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Electrician | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Dorchester | 13c. CITY OR TOWN: Cambridge | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: 111 Linthicum Drive |
| 14. FATHER'S NAME First: DAVID | Middle: HORMAN | Last: JONES SR. | 15. MOTHER'S MAIDEN NAME First: GRACE | Middle: OLEVIA Last: WEEDON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-07-7917 | 17. INFORMANT: Mrs. Mabel Jones | Address: 111 Linthicum Drive Cambridge Md. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the lung
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pneumothorax; Chronic Obstructive lung Disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 9/25/ | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Pneumothorax | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this hospital) attended the deceased from 7-22, 19 75, to 10-1, 19 75, that (I) (we) last saw the deceased alive on ____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: C. Layton Jr MD | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 11/1/75 | |
| 22d. PHYSICIAN'S NAME (Type): C.R. LAYTON, JR. | 22e. ADDRESS | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Nov.4,1975 | 23c. NAME OF CEMETERY OR CREMATORY: E.New Market Cemetery | 23d. LOCATION (City or Town): E. New Market | (County): Dor. (State): Md. |
| 24. FUNERAL DIRECTOR: Thomas Funeral Home | ADDRESS: P.O. Box 348 Cambridge Md. | 25a. DATE: NOV 6 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jones Jr. Asst. Registrar | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28293

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN X ESTIMATED ☐ MONTH DAY YEAR | 11-16-75 | 2b. HOUR | 1:35 PM |
| MILLARD | T. | LONG | | | | |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS) LAST BIRTHDAY | IF UNDER 1 YR. MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Male | White | 4 10 1898 | 77 YRS. | | | | | 11-16-75 19 | 11 M |

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| MD. | U.S.A. | | Wicomico MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | RETIRED FARMER | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Somerset | Westover | YES ☐ NO ☐ | General Delivery |

| 14. FATHER'S NAME FIRST MIDDLE LAST | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST |
|---|---|
| MILLARD LONG | IDA BOZMAM |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| NO | | MRS. RUTH LONG WESTOVER, MD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | sudden |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 4122 | DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive Cardiovascular Disease | years |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Peritonitis.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO X |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Earl L. Royer TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER DATE SIGNED 11-17-75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN COUNTY STATE |
|---|---|---|---|
| BURIAL | II/L9/I975 | OLIVER T. BEAUCHAMP CEM. | PRINCESS ANNE, MD. |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Wilson Funeral Home, Princess Anne, Md. | NOV 21 1975 | Irene Jan Matthews ACTING REGISTRAR |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M 1/73
(VR A15 ME (5))

75-28203

FARMER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28294

1. DECEASED-NAME (Type or print): First MARIE Middle Last MALCOM
2a. DATE OF DEATH: Month NOVEMBER Day 4 Year 1975
2b. HOUR: 5 04 PM
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: Aug. 26, 1920
6. AGE (In years last birthday): 55 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): KY.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hsp.
12a. USUAL OCCUPATION (Kind of wark done during mast of warking life, even if retired.): INSPECTOR
12b. KIND OF BUSINESS OR INDUSTRY: CLOTHING
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD
13b. COUNTY: WI
13c. CITY OR TOWN: SALISBURY
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: MERRITT MILL RD
14. FATHER'S NAME First JAMES Middle MONROE Last McGILLA
15. MOTHER'S MAIDEN NAME First ANNA Middle MAUDE Last BRAME
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dates of service)
16b. SOCIAL SECURITY NO.: 527-30-5546
17. INFORMANT: MR. BRICE O MALCOM Address: RD 3 MERRITT MILL RD SALISBURY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the stomach
DUE TO, OR AS A CONSEQUENCE OF
(b): With pleural metastasis.
DUE TO, OR AS A CONSEQUENCE OF
(c): And A. retroperitoneal nodes.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natity medical exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at wark [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify thot (I) (this hospitol) ottended the deceosed from Feb. 2, 19 75, to Nov. 3, 19 75, thot (I) (we) lost sow the deceosed olive on Nov 3 19 75, and thot in (my) (our) opinion deoth occurred on the dote and hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE: Helen M. Baldado M.D. DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type): HELEN M. BALDADO
22e. ADDRESS: 237 FLORIDA AVE. SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Nov. 8, 1975
23c. NAME OF CEMETERY OR CREMATORY: WICOMICO MEM. PARK
23d. LOCATION (City or Town) (County) (State): SALISBURY Wi MD
24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME SALISBURY MD
25a. REC'D BY REGISTRAR DATE: NOV 12 1975
25b. REGISTRAR'S SIGNATURE: Thane Jan Martin ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 7/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

75-28295

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| OLGA | MARGARITE | MANG | November 17 1975 | 4:30 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | June 23, 1900 | 75 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pennsylvania | United States | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | Retired Waitress | Food |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | 309 Brookview Drive |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Levi | David | Stiffler | Linnie | Mae | Keckler |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | | 174-18-0307 | Mr. Julius Stiffler, Hyattsville, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary edema - — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD & Renal failure
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis & Diabetes Mellitus

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pyloric Stenosis.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 11/4, 19 75, to 11/17, 19 75, that (I) (we) last saw the deceased alive on 11/17 19 75, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 11/17/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| JOSEPH Z. BADROS | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/19/75 | Carson Valley Cemetery | Carson Valley, Blair, Pa. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 20 1975 | [signature] ACTING REGISTRAR |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

Item#6 filmg491 1/14/76 sv

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28296

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the person in charge of the funeral. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Dr Raymond Dunsmore | | MARKLE | NOVEMBER | 28 | 1975 | 9:45 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| Male | White | Dec 18, 1910 | 64 ~~65~~ YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH | | | |
| Waterbury, Conn | USA | | Wicomico | | | Md |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | Peninsula General Hospital | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | |
| Delaware | Sussex | Rehoboth | YES ☐ NO ☒ | Sea AircMobile City | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | |
| Ira | | Markle | Grace | | Hunter | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address | | |
| | | | Paul Markle | Lewes, Delaware | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Advanced Cirrhosis Lived with Hepatic Coma. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

5710

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Heavy Ethanol ingestion

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriolar nephrosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Anuria due to Hepatorenal Syndrome, Bleeding diathesis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | |

| 21a. ACCIDENT WAS (If either, natify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 11-13-75, 19____, to 11-28-75, 19____, that (I) (we) last saw the deceased alive on 11-28-75 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Bal K Agarwal | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 11/28 |
| 22d. PHYSICIAN'S NAME (Type) BAL K. AGARWAL | 22e. ADDRESS PGH. | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | | Silverbrook Cemetery | Wilmington Newcastle Delaware |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
| Watson Funeral Home | Pocomoc, Maryland | DEC 11 1975 | ACTING REGISTRAR |

DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

75-28297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

1. DECEASED-NAME (Type or print) First: L. Herman Middle: Last: Merrill

2a. DATE OF DEATH Month: 11 Day: 24 Year: 75

2b. HOUR: 4 AM PM

3. SEX: male

4. RACE: white

5. DATE OF BIRTH: 12-13-93

6. AGE (In years last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN

7a. BIRTHPLACE (State or foreign country): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

9. COUNTY OF DEATH: Wicomico Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Furniture

12b. KIND OF BUSINESS OR INDUSTRY: Merchant

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Worcester

13c. CITY OR TOWN: POcomoke

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET AND NUMBER: Market Street Ext.

14. FATHER'S NAME First: John Middle: Thomas Last: Merrill

15. MOTHER'S MAIDEN NAME First: Florence Middle: V. Last: Smith

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WW1 Army

16b. SOCIAL SECURITY NO.: 213-05-2024

17. INFORMANT: C. Hargest Merrill Address: Cedar Hall Rd. Pocomoke City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Week
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — Yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9/8, 19 75, to 11/20, 19 75, that (I) (we) last saw the deceased alive on 11/24, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Earl Beardsley M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 11/25/75

22d. PHYSICIAN'S NAME (Type): EARL M. BEARDSLEY, M.D.

22e. ADDRESS: u.s.50 at CIVIC AVE., SALISBURY, MD. 21801

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/28/75

23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Episcopal Cem.

23d. LOCATION (City or Town) (County) (State): Pocomoke Worcester Md

24. FUNERAL DIRECTOR: Scott E. Nelson ADDRESS: Pocomoke City, Md.

25a. REC'D BY REGISTRAR DATE: DEC 02 1975

25b. REGISTRAR'S SIGNATURE: Anne Jan Matthews ACTING REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28298
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | |
| DARTHULA | CATHERINE | MILLER | November 16, 1975 | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| Female | White | April 23, 1883 | 92 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Virginia | United States | | WICOMICO MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | R.D. 4, Wango Road | | Housewife | ---- | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES ☐ NO ☒ | R.D. 4, Johnson Road |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Patton | | Miller | Emma | | Dye |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Daughter) ADDRESS Johnson Road |
|---|---|---|---|
| No | | 226-22-9224 | Mrs. Posey Shupe, Salisbury, Maryland |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 428X | IMMEDIATE CAUSE (a) Pneumonia | 2 days |
| Conditions, if ony, which gove rise to immediote couse (a), stating the underlying couse lost. | DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Insufficiency | 20 yrs |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 19 75, to 11-1, 19 75, that (I) (we) last saw the deceased alive on 11-1, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| W B Smith | MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐ | 11/18/75 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS | |
| Dr. William B. Smith | Camden Ave., Salisbury, Maryland | |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/18/75 | Springhill Memory Gardens | Salisbury, Wic., Maryland |

| 24. FUNERAL DIRECTOR NAME ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 20 1975 | Thomas Jan Martin ACTING REGISTRAR |

BP

DHMM - 16-25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28299

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Margaret | MIDDLE: | LAST: MILLER | 2a. DATE OF DEATH MONTH DAY YEAR: November 25 1975 | 2b. HOUR: 10:30 P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: January 15 1922 | 6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Virginia US - Unknown | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: none | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | YES [X] NO [ ] | 400 Newton Terrace |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| John | Paul | Kordish | Fannie | Frances | Orbe |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 235-24-0878 | Robert J. Miller, (son) Salisbury, Md. Deer's Head Center Records |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of breast c gen. metastasis.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1744
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4y

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | YES [ ] NO [ ] |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that (I) (this hospital) attended the deceased from August 13, 1975, to November 25, 1975, that (I) (we) last saw the deceased alive on November 25 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did [ ] did not view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Leonid Maldve | ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] | 11/25/75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Leonid V. Maldve, MD | Deer's Head Center, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/28/75 | Parsonsburg Cem | Parsonsburg Wi Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME SALISBURY, MARYLAND | DEC 01 1975 | Frances Jean Parker ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 3D1 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

75-28300
REG. NO.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | Joseph Henry Morgan | 2a. DATE OF DEATH MONTH DAY YEAR | November 11, 1975 |
| | | 2b. HOUR | 12:45p M |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH MONTH DAY YEAR | April 4, 1900 | 6. AGE (IN YEARS LAST BIRTHDAY) | 75 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS HOURS / MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Va. | 7b. CITIZEN OF WHAT COUNTRY? | USA |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | 9. BALTIMORE CITY OR COUNTY OF DEATH | Wicomico MD. |
| 10. CITY OR TOWN OF DEATH | Sharptown | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12 Park Avenue |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Service Station | 12b. KIND OF BUSINESS OR INDUSTRY | Retail Petro. |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Md. | 13b. COUNTY | Wicomico |
| 13c. CITY OR TOWN | Sharptown | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | |
| 13e. STREET ADDRESS | 12 Park Avenue | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | James Henry Morgan | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Martha Elizabeth Davis |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | (IF YES, GIVE WAR OR DATES) | |
| 16b. SOCIAL SECURITY NO. | 220-16-7583 | 17. INFORMANT ADDRESS | Martha E. Morgan Sharptown, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Old Myocardial Infarction Due | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic Heart Disease | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? YES [ ] NO [X] | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH [ ] (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from May 12, 19 62, to Nov. 11, 19 75, that (I) (~~saw~~) last saw the deceased alive on Sept 9, 19 75, and that in (my) (~~this~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~have~~) (~~did~~ did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Thomas C Hall Jr | DEGREE | M.D. ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] |
| 22c. DATE SIGNED | 11-13-75 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | Pine Bluff Road, Salisbury, Md |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 11-14-75 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Riverton Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | Riverton, Wicomico, Md. | |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | Ulrich Funeral Home Sharptown, Md. | 25a. DATE RECEIVED BY REGISTRAR | NOV 19 1975 | 25b. REGISTRAR'S SIGNATURE ACTING REGISTRAR |

DHMH-16 60M 1-73
(VR A 15 (4))

12-59300

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28301

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ELLA | Middle: | Last: Morris | 2a. DATE OF DEATH Month: 11 Day: 19 Year: 75 | 2b. HOUR: 945 AM |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH: 3-02-05 | 6. AGE (In years last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Md. Wico | 7b. CITIZEN OF WHAT COUNTRY?: U.S. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico | | Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wicomico Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER: 142 Davis St. | |
| 14. FATHER'S NAME First: unk | Middle: | Last: | 15. MOTHER'S MAIDEN NAME First: unk | Middle: | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-18-4162 | 17. INFORMANT: Wico. Nursing Home | Address: | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4360
IMMEDIATE CAUSE (a): Cerebrovascular accident
DUE TO, OR AS A CONSEQUENCE OF
(b): Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c): Hypertension
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 1-19, 1971, to 11-19, 1975, that (I) (we) last saw the deceased alive on 11-18 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A. C. Mitchell DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☐ 22c. DATE SIGNED: 11/20/75

22d. PHYSICIAN'S NAME (Type): A. C. Mitchell, M. D. 22e. ADDRESS: Fruitland, Maryland

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE: 11-23-75 | 23c. NAME OF CEMETERY OR CREMATORY: Glass Hill Cemetery | 23d. LOCATION (City or Town): Parsonsburg | (County): Wico. | (State): Md. |
| 24. FUNERAL DIRECTOR: Russell Tooks Funeral Home | ADDRESS: P.O.B. 294 Sharptown | 25a. REC'D BY REGISTRAR DATE: DEC 2 1975 | 25b. REGISTRAR'S SIGNATURE: Marie J. Martin ACTING REGISTRAR | | |

DHMH-16 1/71 30M
(VR A15 (4))

Inf. added filmg489 11/20/75 sv

# STATE OF MARYLAND
# DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

75-28302

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 (VR A15 (4))

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| GEORGE | | MOSBURGER | November | 4 | 1975 | 11:15 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | Cauc. | 6/9/02 | 73 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Germany | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| salisbury | Peninsula General Hsp. | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Wicomico | O.C. | YES ☒ NO ☐ | 134 Pine tree Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| | | | | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| no | | 215-32-7726A | Helen Mosburger (same) | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma Lung — 3wk

DUE TO, OR AS A CONSEQUENCE OF (b) Chron Obstruct Lung Dis. — 4yr

DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Emb — 1wk

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 10-17, 1975, to 11-4, 1975, that (I) (we) last saw the deceased alive on 11-4 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Nevins W. Todd | MD | ☒ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| NEVINS W. Todd | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/8/75 | Gardens of Faith | Baltimore, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Paul E. Chenowith Jr. | 3615 Chestnut Ave | NOV 10 1975 | |

Item 8 filmg489 11/13/75 sy

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28303

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Oather; Middle C.; Last MUMFORD
2a. DATE OF DEATH: Month NOVEMBER; Day 3; Year 1975
2b. HOUR: 5:25 PM
3. SEX: Male
4. RACE: Black
5. DATE OF BIRTH: Dec. 8, 1931
6. AGE (In years lost birthday): 43 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Berlin, Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Worcester
13c. CITY OR TOWN: Bishopville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: R.D. 1 Box 40 B
14. FATHER'S NAME: First John; Middle; Last Mumford
15. MOTHER'S MAIDEN NAME: First Nancy Pitts; Middle Mumford; Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): Korean
16b. SOCIAL SECURITY NO.: 218-30-0850
17. INFORMANT: Mildred Mumford; Address: Bishopville, Md

80 35 30 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MASSIVE TO the Intracranial hemorrhage, brain-stem — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs
4319
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X 19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

X 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED: While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION: Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11/3, 1975, to 11/3, 1975, that (I) (we) last saw the deceased alive on 11/3 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alberta Mattax Polin MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 11/3/75

1 22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Nov. 6, 1975
23c. NAME OF CEMETERY OR CREMATORY: New Bethel
23d. LOCATION (City or Town): Berlin (County): Wor. (State): Md.

24. FUNERAL DIRECTOR: Richard T. Watson; ADDRESS: Selbyville, Del.
25a. REC'D BY REGISTRAR: DATE NOV 6 1975
25b. REGISTRAR'S SIGNATURE: Frances [signature] ACTING REGISTRAR

DHMH-16 1/71 30M (VR A15 (4))

15-20303

NOV 6 1975

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28304

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | First | Middle | Last | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | ELLA | POWELL | OWENS | 2a. DATE OF DEATH Month: 11 Day: 22 Year: 75 | 2b. HOUR 1:35 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: FEB 6 1901 | 6. AGE (In years last birthday): 74 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE WIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: WICOMICO | 13c. CITY OR TOWN: WHITON | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: — | | |
| 14. FATHER'S NAME: RUFUS | Middle: DENNIS | Last: | 15. MOTHER'S MAIDEN NAME First: SIGOURNEY | Middle: LEWIS | Last: |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): X | (If yes give war or dates of service): X | 16b. SOCIAL SECURITY NO.: 215-16-3799 | 17. INFORMANT: MANSON OWENS | Address: R.F.D. PITTSVILLE MD | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Arrest | MINS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Congestive Heart Failure | 4 HOURS. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Atherosclerotic Cardiovas. Disease | YRS. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| X | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/14, 19 75, to 11/22, 19 75, that (I) (we) last saw the deceased alive on 11/22 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Donald M. Wood M.D. | | [X] | [ ] | [ ] | 11/22/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Donald M. Wood, M.D. | 215 Ohio Ave., Salisbury, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 11-25-75 | RIVERSIDE | BERLIN WORCESTER Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Peter Whaley | Salisbury, Md. | NOV 28 1975 | Thomas Jan Martin ACTING REGISTRAR |

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28305

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EDGAR | Middle: LAWRENCE | Last: PARKER | 2a. DATE OF DEATH Month: NOVEMBER Day: 13 Year: 1975 | | 2b. HOUR: 4:54 PM |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: February 26, 1898 | 6. AGE (In years last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Sign painter | 12b. KIND OF BUSINESS OR INDUSTRY: painting | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 615 Baker Street | | |
| 14. FATHER'S NAME First: George | Middle: R. | Last: Parker | 15. MOTHER'S MAIDEN NAME First: Nancy | Middle: Jane | Last: Ryne | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217-16-9129 | 17. INFORMANT (wife) | Address: same as 13e | | | |
| | | Mrs. Alice W. Parker, Salisbury, Md. | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO, OR AS A CONSEQUENCE OF (b): ATHSCVD — 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 1/13, 19 71, to 11/13, 19 75, that (I) ~~(we)~~ last saw the deceased alive on 11/13 19 75, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: GH Henning MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 11/ /75

22d. PHYSICIAN'S NAME (Type): Dr. George H. Henning — 22e. ADDRESS: Ocean City Road, Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11/17/75 | 23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery | 23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland | |
| 24. FUNERAL DIRECTOR | ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. REC'D BY REGISTRAR DATE: NOV 19 1975 | 25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

75-28306

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M-1/70

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| THEODORE | F | PARSONS | 11 | 24 | 75 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| MALE | AA | 7-26-1904 | 71 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD | U.S.A | | WICOMICO Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home | farmer | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD | WICOMICO | FRUITLAND | | Rt. Box 280 - Sp. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | F | PARSONS | MARY | E | HARMON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 219-16-7866 | JOHN PARSONS | FRUITLAND MD |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung with metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 11/19, 19 75, to 11/24, 19 75, that (I) (we) last saw the deceased alive on 11/24 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Sally Beardsley MD | | | | | 11/26/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Earl M. Beardsley, M.D. | U.S. 50 at Civic Ave. Salisbury, Md. 21801 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| burial | 11/29/75 | Mt. Calvary Cemetery | Fruitland Wicomico Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| West Funeral Home | | DEC 01 1975 | ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28307

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

1. DECEASED-NAME (Type or print): First: Russell Benson; Middle: Pilchard; Last: Sr.
2a. DATE OF DEATH: Month: November; Day: 22; Year: 75
2b. HOUR: 3A M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: Jan. 12, 1895
6. AGE (In years last birthday): 80 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman
12b. KIND OF BUSINESS OR INDUSTRY: Automobile
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Girdletree
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER
14. FATHER'S NAME: First: J. Washington; Middle: ; Last: Pilchard
15. MOTHER'S MAIDEN NAME: First: Susan; Middle: ; Last: Hancock
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 212107629
17. INFORMANT: Mrs. Martha B. Pilchard
Address: Girdletree, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): upper GI hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(b): duodenal ulcer
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5310
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days / ulcer

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
arthritis

19a. DATE OF OPERATION: X
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner): X
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11-19, 19 75, to 11-22, 19 75, that (I) (we) last saw the deceased alive on 11-22 19 75 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William A. Elliott Jr. DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 11-22-75
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-24-75
23c. NAME OF CEMETERY OR CREMATORY: Baptist
23d. LOCATION (City or Town) (County) (State): Girdletree, Md.
24. FUNERAL DIRECTOR: Truman E. Holloway
ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: NOV 25 1975
25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28308

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: WILLIAM | Middle: A. | Last: POWELL |
| 2a. DATE OF DEATH | Month: 11 | Day: 6 | Year: 1975 |
| 2b. HOUR | 32 17 M | | |
| 3. SEX | male | | |
| 4. RACE | white | | |
| 5. DATE OF BIRTH | May 27, 1909 | | |
| 6. AGE (In years last birthday) | 66 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | |
| 9. COUNTY OF DEATH | Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hsp. | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Del-Mar-Va Power | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | | |
| 13b. COUNTY | Worcester | | |
| 13c. CITY OR TOWN | Pocomoke | | |
| 13d. INSIDE CITY LIMITS? | YES [X] NO [ ] | | |
| 13e. STREET AND NUMBER | 1404 Linden Drive | | |
| 14. FATHER'S NAME | First: John | Middle: W. | Last: Powell |
| 15. MOTHER'S MAIDEN NAME | First: Arentha | Middle: | Last: Pusey |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | yes | (If yes, give war or dates of service) WW 2 Army | |
| 16b. SOCIAL SECURITY NO. | 217-09-0771 | | |
| 17. INFORMANT | John Hayman Powell | Address: Newark, Delaware | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] lung & bone metastases
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this hospital) attended the deceased from 10/20, 19 75, to 11/6, 19 75, thot (I) (we) last saw the deceased olive on 11/6 19 75, and thot in (my) (our) opinion deoth occurred on the dote and hour ond from the couses stated above, (I) (we) (did) ~~(did not)~~ view the body after deoth.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Horner MD | DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED 11/6/75 |
| 22d. PHYSICIAN'S NAME (Type) | WILLIAM B. HORNER M.D. | 22e. ADDRESS | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | 11/9/75 | Bethany Methodist Cem. | Pocomoke | Worcester Md. |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| [illegible] Dodson | Pocomoke City, Md | NOV 12 1975 | [illegible] ACTING REGISTRAR | |

DHMH-16 1/71 30M
(VR A15 (4))

1- FOR STATE REGISTRAR — REVISED COPY

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REVISED COPY — REG. NO. 75 028309

| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST |
|---|---|---|
| GERALD | WALTER | PROPPER |

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☒ — MONTH DAY YEAR: 11-21-75 — 2b. HOUR: 9:15 P.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH (MONTH DAY YEAR) | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 4 6 27 | 48 YRS. | | |

2c. DATE PRONOUNCED DEAD: MONTH DAY YEAR 11-21-75 19 — 2d. HOUR: 9:42 P.M.

| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH |
|---|---|---|---|
| Ohio | U.S.A. | | Wicomico MD. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | DOA Peninsula General | Auto Serv. Mgr. | Auto Store |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Wicomico | Salisbury | YES ☒ NO ☐ | 1022 Pierce Ave. |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| Walter | Livingston | Propper | Hazel | Lillian | Brown |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW II | 288-20-5562 | Mrs. Anna E. Propper (wife) same as 13 |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Asphyxia | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carbon Monoxide Poisoning | minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

8180 — Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 9 P.M. 11-21-75 | Drove car with tailpipe missing. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | parking lot, | A & P Store, Salisbury, Wicomico, Md. |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Naturol coures ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐,

ACTUAL SIGNATURE [signature] M.D. — TITLE (SPECIFY) Deputy MEDICAL EXAMINER — DATE SIGNED 12-1-75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. — ADDRESS 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/24/75 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Holloway Funeral Home, Salisbury, Md. | DEC 05 1975 | [signature] ACTING REGISTRAR |

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M 1/73 (VR A15 ME (5))

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Health prior to burial, cremation, or removal, and in any event within 72 hours after death. 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of

VR A15ME (5)
10M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-28310

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| EARL | FOX | RAHN | 11 | 6 | 1975 | 4:45 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | Oct 4, 1897 | 78 YRS. | | | | | 11 | 6 | 1975 | 4:45 P |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Pa. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | 119 Lakeview Dr., | Retired Clergyman | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Salisbury | | 119 Lakeview Dr., |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | H | Rahman | Sallie | | Fox |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | W.W.I | 200-30-4260 | Mrs. Donald Bauer | see sec 13 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

22b. DATE SIGNED 11-6-1975

EXAMINER'S NAME (Type) Dr. Earl L. Royer ADDRESS (Street, city, town, county) Camden Ave., Salisbury, Maryland Wicomico

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Cremation | 11-7-1975 | J.Wm. Lee's Crematory | Washington, D.C. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Hill-Baker-Bounds Funeral Home Salisbury, Md. | NOV 10 1975 | Thomas Jean Martin ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28311

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH MONTH DAY YEAR | 2b. HOUR | | |
| ROGER | FRANCIS | RICHARDSON | November 19, 1975 | M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | |
| Male | White | November 9, 1895 | 80 YRS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | United States | | WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | Peninsula General Hospital | Farmer | Farming | | | |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Maryland | Wicomico | Eden | YES ☐ NO ☒ | Rt. 1, Old Furnace Road |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| George | Thomas | Richardson | Annie | | Maddux |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 215-36-1696A | Mrs. Louise P. Richardson (wife) | same as 13 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Hypovolemic Shock | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Ruptured Aneurysm of Right | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Internal Bleed | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 6PM 11/14, 19 75, to 9PM 11/19, 19 75, that (I) (we) last saw the deceased alive on 9:40PM 11/19, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | 22c. DATE SIGNED |
|---|---|---|---|
| Helen M. Baldado | M.D. | ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ | 11/20/75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. ~~Howard Hughes~~ Helen M. Baldado | ~~Medical Center~~, Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/22/75 | Olivet Cemetery | Worcester Co., Md. |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 24 1975 | Diane Jean Marthen ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28312

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) | FIRST: ROY | MIDDLE: WILSON | LAST: RIGGIN |
| 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] | MONTH: 11 | DAY: 19 | YEAR: 75 |
| 2b. HOUR | 8:55 A.M. | | |
| 3. SEX | Male | | |
| 4. RACE | White | | |
| 5. DATE OF BIRTH | MONTH: May | DAY: 29, | YEAR: 1916 |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 59 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
| 2c. DATE PRONOUNCED DEAD | MONTH: November | DAY: 19 | YEAR: 19 75 |
| 2d. HOUR | 11 M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | |
| 7b. CITIZEN OF WHAT COUNTRY? | United States | | |
| 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | ~~WORCESTER~~ Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH | ~~Whitesburg~~ Salisbury | | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Peninsula General Hospital DOA | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Farmer | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Farming | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| | | | | |
|---|---|---|---|---|
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | Somerset | Princess Anne | YES [ ] NO [X] | Rt. 2, Fleming Mill Road |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME | FIRST: Elmer | MIDDLE: Paul | LAST: Riggin |
| 15. MOTHER'S MAIDEN NAME | FIRST: Clara | MIDDLE: Ellen (Ella) | LAST: Brumbley |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | Yes | (IF YES, GIVE WAR OR DATES) WW II | |
| 16b. SOCIAL SECURITY NO. | 217-16-9145 | | |
| 17. INFORMANT (brother) ADDRESS | Mr. Orville Riggin, Snow Hill Md. | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

4109

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11/20/75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M. D. ADDRESS 409 Camden Ave., Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN | COUNTY / STATE |
| Burial | 11/22/75 | Olivet Cemetery | | Worcester Co., Md. |

| | | | |
|---|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS | HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. DATE REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
| | | NOV 24 1975 | [signature] ACTING REGISTRAR |

BP

DHMH - 17
(VR A15 ME (5))
30M 7/73

75-20312

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28313

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: ETHEL | MIDDLE: V. | LAST: ROSS | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 9 YEAR 75 | 2b. HOUR 10:40 P M | | | |
| 3. SEX: F | 4. RACE: W | 5. DATE OF BIRTH MONTH 1 DAY 28 YEAR 21 | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH 11 DAY 9 YEAR 75 | 2d. HOUR 11 M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Whitsburg, Md | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DOA Peninsula General | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Princess Anne | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: Box 251 C Warwick Trailer Park | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST: Elmer P. Riggin | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Clara Ela Brumley Riggin | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): no (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 218-24-4028 | 17. INFORMANT: Mr. Willard L. Ross Sr. | ADDRESS: RT #2 box 123 Prin. Anne | | | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: weeks
4270
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
| 21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: [signature] M.D. TITLE (SPECIFY): Deputy MEDICAL EXAMINER DATE SIGNED: 11-11-75

EXAMINER'S NAME (TYPE OR PRINT): Earl L. Royer, M.D. ADDRESS: 409 Camden Ave., Salisbury, Md.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11-12-75 | 23c. NAME OF CEMETERY OR CREMATORY: Olivet cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE: Princess Anne Wor Md. | |
| 24. FUNERAL DIRECTOR NAME: Watson Funeral Home | ADDRESS: Scott E. Milson, Pocomoke, Md. | 25a. DATE REC'D. BY REGISTRAR: NOV 14 1975 | 25b. REGISTRAR'S SIGNATURE: [signature] ACTING REGISTRAR | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M-1-73
(VR A15-ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28314

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES | MIDDLE: Sidney | LAST: Russell | 2a. DATE OF DEATH MONTH: November | DAY: 12 | YEAR: 75 |
| 2b. HOUR: 630 A M | | | | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH MONTH: July | DAY: 9, | YEAR: 1893 | |
| 6. AGE (IN YEARS LAST BIRTHDAY): 82 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN: | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Plant Mgr | 12b. KIND OF BUSINESS OR INDUSTRY: Telephone Co | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Wico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET ADDRESS: 603 N. Pinehurst Ave | |
| 14. FATHER'S NAME FIRST: William | MIDDLE: H. | LAST: Russell | 15. MOTHER'S MAIDEN NAME FIRST: Mamie | MIDDLE: | LAST: Johnson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes | (IF YES, GIVE WAR OR DATES): WWI | 16b. SOCIAL SECURITY NO.: 212-10-0612 | 17. INFORMANT: Gladys Hacket Russell | ADDRESS: Same | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): subarachnoid hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b): hyperextension
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
4300
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ] |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Nov. 11, 19 75, to NOV. 12 19 75, that (I) (~~me~~) last saw the deceased alive on NOV. 11 19 75, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the couses stoted above, (I) (~~me~~) (did) (~~did not~~) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Rodney A. Wenrich | DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ] | 22c. DATE SIGNED: 11/12/75 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): RODNEY A. WENRICH | 22e. ADDRESS: KAY AVE, SALISBURY Md. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL | 23b. DATE: 11/14/1975 | 23c. NAME OF CEMETERY OR CREMATORY: Wood. Mem. Pk. | 23d. LOCATION CITY OR TOWN: Salisbury | COUNTY / STATE: Md. |
| 24. FUNERAL DIRECTOR NAME: Hill-Baker-Bounds | ADDRESS: Salisbury Md. | 25a. DATE REC'D. BY REGISTRAR: NOV 14 1975 | 25b. REGISTRAR'S SIGNATURE: Thane Joan Matthew | |

ACTING REGISTRAR

DHMH-16 60M 1/73
(VR A 15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

75-28315

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Regina Middle: E. Last: Selby | 2a. DATE OF DEATH Month: Nov. Day: 24 Year: 1975 | 2b. HOUR M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: June 9, 1891 | 6. AGE (In years last birthday): 84 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Postmaster | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Virginia | 13b. COUNTY: Accomack | 13c. CITY OR TOWN: Greenbackville | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET AND NUMBER: Main Street |
| 14. FATHER'S NAME First: Levi Middle: Last: Harrison | 15. MOTHER'S MAIDEN NAME First: Maggie Middle: Last: Lindsey | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 228-05-8278 | 17. INFORMANT: Edwin H. Selby Old Snow Hill Road Pocomoke City, Md. | |

90
83
701
3

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4339

IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 mo.

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yes

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

X

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 7/22, 1975, to 11/24, 1975, that (I) (we) last saw the deceased alive on 11/22 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11/24/75

22d. PHYSICIAN'S NAME (Type): Earl M. Beardsley, M.D. | 22e. ADDRESS: U.S. 50 at Civic Ave., Salisbury, Md 21801

1

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/28/75 | Loudon Park Cemetery | Baltimore Baltimore Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Scott S. Nelson | Pocomoke City, Md. | DATE DEC 03 1975 | Thomas Jan Martha |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28316

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1-71 30M
(VR 415 (4))

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Lena | M. | Serman | 11 | 7 | 75 | 12 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | Cauc. | 11-4-85 | 90 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Wicomico Nursing Home | HOUSEWIFE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Wic. | Salis. | YES ☑ NO ☐ | 504 S. Division St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Merrill | | Morris | MARY | | (UNKNOWN) |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| | | 213-74-9345 | Mr. Clyde Serman (son) | E. Vine St. Salisbury, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis (cervix)

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c) Congestive heart failure.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 7-16, 1973, to 11-7, 1975, that (I) (we) last saw the deceased alive on 10-8 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| A. C. Mitchell MD | | ☐ | ☑ | ☐ | 11/10/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| A. C. Mitchell, M. D. | Fruitland, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 11/10/75 | Parsons Cemetery | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Holloway Funeral Home | Salisbury, Md. | NOV 12 1975 | ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28317

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | EVERETT | Middle J. | Last Smith |
| 2a. DATE OF DEATH Month Day Year | NOV. 19 | 75 | 2b. HOUR 7:25 AM |
| 3. SEX | M | | |
| 4. RACE | NEGRO | | |
| 5. DATE OF BIRTH | AUG. 20, 1895 | | |
| 6. AGE (In years last birthday) | 80 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) | Delmar, Del. | | |
| 7b. CITIZEN OF WHAT COUNTRY? | USA | | |
| 8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☒ DIVORCED ☐ | | | |
| 9. COUNTY OF DEATH | Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hsp. | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | LABORER | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | DELAWARE | | |
| 13b. COUNTY | ESSEX | | |
| 13c. CITY OR TOWN | Delmar | | |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | | |
| 13e. STREET AND NUMBER | Rt #2, Box 18A - Del. Delmar | | |
| 14. FATHER'S NAME First | UNKNOWN | Middle | Last |
| 15. MOTHER'S MAIDEN NAME First | Lillian | Middle | Last Mitchell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address | Thelma E. Young - P.O. Box 64 Vienna, Md. | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer lung & gen. metastasis
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 wk

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| | | | |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. I certify that (I) (this hospital) attended the deceased from 10-01, 19 75, to 11-19, 19 75, that (I) (we) last saw the deceased alive on 11-19 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 11-19-75. |
| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| BURIAL | 11-24-75 | Nebo United | Columbia Wico. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS | Jolley Memorial Chapel - Salis. Md. | 25a. REC'D BY REGISTRAR DATE | NOV 24 1975 | 25b. REGISTRAR'S SIGNATURE ACTING REGISTRAR |

DHMH-16 (7/71) 30M
(VR A15 (4))

75-28317

Item #2a film 490 12/9/75 sy

Items 21a-21f Film 490 12/10

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

75-28318

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print): First: Naomi; Middle: Pearl; Last: Smith

2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐: Month Nov. Day 26 Year 19 75

2b. HOUR: M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH: Feb. 17, 1904

6. AGE (In years last birthday): 71 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.

2c. DATE PRONOUNCED DEAD: Month November Day 26 Year 19 75

2d. HOUR: 1045 M

7a. BIRTHPLACE (State or foreign country): Minn.

7b. CITIZEN OF WHAT COUNTRY?: United States

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. COUNTY OF DEATH: WICOMICO Md.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hosp. DOA

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife

12b. KIND OF BUSINESS OR INDUSTRY: ---

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland

13b. COUNTY: Wicomico

13c. CITY OR TOWN: Salisbury

13d. INSIDE CITY LIMITS? YES ☐ NO ☐

13e. STREET AND NUMBER: 920 E. Church St.

14. FATHER'S NAME: First Benjamin Middle Franklin Last Beard

15. MOTHER'S MAIDEN NAME: First Bertha Middle Christina Last Lass

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16b. SOCIAL SECURITY NO.: 218-05-8775

17. INFORMANT ADDRESS: Mr. William T. Smith (Husband) same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fractured Skull - crushed chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 11 26 75

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Auto Accident

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): 60 Ft. Rd. & Rt. 346

21f. LOCATION Street or R.F.D. No. / City or Town: Pittsville / County: Wic. / State: Md.

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip A. Tuslay Sr M.D.

EXAMINER'S NAME (Type): Philip A. Tuslay Sr M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 11-26-75

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/29/75

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR: HOLLOWA[illegible]NERAL HOME, Salisbury, Maryland

ADDRESS

25a. REC'D BY REGISTRAR DATE: DEC 01 1975

25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin ACTING REGISTRAR

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR 1 - STATE REGISTRAR

REG. NO. 75-28319

1. DECEASED NAME (TYPE OR PRINT) — FIRST: ~~Dewey~~ Admiral; MIDDLE: Dewey; LAST: Smullen
2a. DATE OF DEATH — MONTH DAY YEAR: 11/21/75
2b. HOUR: 3:30 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH DAY: 4 11 1900
6. AGE (IN YEARS LAST BIRTHDAY): 75 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: United States
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Health Care Center of Salisbury
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Carpenter
12b. KIND OF BUSINESS OR INDUSTRY: Furniture

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET ADDRESS: 405 Hastings St.

14. FATHER'S NAME — FIRST: Walter; MIDDLE: ; LAST: Smullen
15. MOTHER'S MAIDEN NAME — FIRST: Mollie; MIDDLE: ; LAST: Messick
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No — (IF YES, GIVE WAR OR DATES):
16b. SOCIAL SECURITY NO.: 217-10-3673
17. INFORMANT — ADDRESS: Mrs. Rada T. Smullen (Wife) same as 13

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Acute Gastritis

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET, CITY OR TOWN, COUNTY, STATE

22a. I certify that (1) (this hospital) attended the deceased from Oct 8, 19 75, to Nov 21, 19 75, that (I) ~~saw~~ last saw the deceased alive on Nov. 20 19 75, and that in (my) (~~the~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~did~~) (did not) view the body after death.
22b. SIGNATURE: Thomas C Hill Jr M D — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 11-21-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): THOMAS C. Hill Jr. M.D.
22e. ADDRESS: Pine Bluff Road, Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11/24/75
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION — CITY OR TOWN, COUNTY, STATE: Salisbury, Wic., Maryland
24. FUNERAL DIRECTOR — NAME, ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland
25a. DATE REC'D. BY REGISTRAR: NOV 25 1975
25b. REGISTRAR'S SIGNATURE: Thomas Jean Matthew — ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28320

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH 16 1/71 30M
(YR A15 (4))

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Noah | Henry | Stanley | November | 23 | 1975 | 2:45 p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| M | Negro | 7-22-1902 | 73 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Wicomico | Sharptown | YES ☐ NO ☒ | P.O. Box 288 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Jeffrey | | Stanley | Ida | | Smiley |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| | | 221-10-1390A | Gladys M. Stanley | (Same As Above) |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Liver Metastasis. | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Ca Colon. Post Op Stroke. | |

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

1538

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natity medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this haspital) attended the deceased from 11-23, 1975, ta 11-23, 1975, that (I) (we) last saw the deceased alive an 11-23 1975, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| | | ☒ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| V.S. Rao, M.D. | Salisbury, Md. Florida Ave. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | 11-29-75 | ZION United M. | Sharptown | Wico. | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Jolley Memorial Chapel | Salisbury Md | DEC 01 1975 | ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28321

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP ✓

DHMH - 16 25M
(VR A 15 (4) ) 9/74

| | | | | |
|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST | MOLLIE | WAINWRIGHT | STEVENSON | |
| 2a. DATE OF DEATH MONTH DAY YEAR | November 8, 1975 | | | |
| 2b. HOUR | 1:55 P.M. | | | |
| 3. SEX | Female | | | |
| 4. RACE | White | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR | May 29, 1896 | | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) | 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | Maryland | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | United States | | | |
| 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | | | | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH | WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH | Salisbury | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | Salisbury Nursing Home | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | Housewife | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | none | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE | Maryland | | | |
| 13b. COUNTY | Wicomico | | | |
| 13c. CITY OR TOWN | Salisbury | | | |
| 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | | | |
| 13e. STREET ADDRESS | R.D. 1, #379 | | | |
| 14. FATHER'S NAME FIRST / MIDDLE / LAST | Ota | Francis | Bounds | |
| 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST | Magnolia (Maggie) | | Townsend | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | No | | | |
| (IF YES, GIVE WAR OR DATES) | | | | |
| 16b. SOCIAL SECURITY NO. | | | | |
| 17. INFORMANT (son) ADDRESS | R.D. 1, #324 Mr. Ota J. Stevenson, Salisbury, Md. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Myocardial failure | 10 mins |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Hypertension | Many years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriosclerotic heart disease | Many years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 412.1

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinsonism

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from August, 19 75, to November, 19 75, that (I) ~~(we)~~ last saw the deceased alive on Nov. 8th, 19 75 and that in (my) ~~(our)~~ opinion death occurred at the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Dorothy C. Holzworth | DEGREE | M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ |
| 22c. DATE SIGNED | 11/10/75 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | Dr. Dorothy C. Holzworth | 22e. ADDRESS | 104 N. Bay Street, Snow Hill, Maryland |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | Burial | 23b. DATE | 11/10/75 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Olivet Cemetery | 23d. LOCATION CITY OR TOWN / COUNTY / STATE | | Worcester, Md. |
| 24. FUNERAL DIRECTOR NAME / ADDRESS | HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. DATE REC'D. BY REGISTRAR | NOV 14 1975 | 25b. REGISTRAR'S SIGNATURE Thomas Jan Martin ACTING REGISTRAR |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28322

1. DECEASED NAME (TYPE OR PRINT): FIRST JERRY; MIDDLE ALLEN; LAST SUMMERFIELD

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] MONTH 11 DAY 21 YEAR 75 — 2b. HOUR 4:35 P.M.

3. SEX: Male — 4. RACE: White — 5. DATE OF BIRTH: MONTH 1 DAY 2 YEAR 39 — 6. AGE (IN YEARS LAST BIRTHDAY): 36 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 21 YEAR 75 — 2d. HOUR " M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): W. Va.

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): store owner

12b. KIND OF BUSINESS OR INDUSTRY: furniture

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md. — 13b. COUNTY: Wicomico — 13c. CITY OR TOWN: Hebron — 13d. INSIDE CITY LIMITS? YES [ ] NO [ ] — 13e. STREET ADDRESS: Rt. 1, Box 47

14. FATHER'S NAME: FIRST Olen; MIDDLE P.; LAST Summerfield

15. MOTHER'S MAIDEN NAME: FIRST Elizabeth; MIDDLE - - - -; LAST Harper

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES): Yes-Army

16b. SOCIAL SECURITY NO.: 235-56-9847

17. INFORMANT (wife) ADDRESS: Mrs. Iva Lou Summerfield, same as 13

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b): Rupture of Spleen and Left Kidney — 4 hrs.
DUE TO, OR AS A CONSEQUENCE OF
(c):

8190
Conditions, if any, which gave rise to immediate cause (a) stating the underlying couse last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION: 11-21-75

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?: Ruptured spleen, left kidney & diaphragm.

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [X] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR 12:03 P.M. MONTH 11 DAY 21 YEAR 75

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver of truck involved in accident.

21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET; CITY OR TOWN; COUNTY; STATE: intersection, Rt. 13 & 413, Westover, Somerset, Md.

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Naturol coures [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ],

ACTUAL SIGNATURE: Earl L. Royer — TITLE (SPECIFY): M.D. Deputy MEDICAL EXAMINER — DATE SIGNED: 11-22-75

EXAMINER'S NAME (TYPE OR PRINT): Earl L. Royer, M.D. — ADDRESS: 409 Camden Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial — 23b. DATE: 11/25/75 — 23c. NAME OF CEMETERY OR CREMATORY: Elk Hill Memory Park — 23d. LOCATION CITY OR TOWN; COUNTY; STATE: Big Chimney -Kanawha W/Va.

24. FUNERAL DIRECTOR NAME; ADDRESS: Holloway Funeral Home, Salisbury, Md.

25a. DATE REC'D. BY REGISTRAR: NOV 25 1975 — 25b. REGISTRAR'S SIGNATURE: Thomas Jan Martin ACTING REGISTRAR

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL

DHMH-17 20M 1/73
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28323

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: Mattie MIDDLE: V. LAST: SYKES | | | 2a. DATE OF DEATH MONTH DAY YEAR: November 28, 1975 — 2b. HOUR: 4:20 A M |
| 3. SEX: Female | 4. RACE: Negro | 5. DATE OF BIRTH MONTH DAY YEAR: May 2, 1922 | 6. AGE (IN YEARS LAST BIRTHDAY): 53 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): U.S.(Unknown) | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Campbell Soup | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Salisbury | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET ADDRESS: 719 Rose Street |
| 14. FATHER'S NAME FIRST MIDDLE LAST: Joe Bob Sykes | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Rosie Harrison | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 223-16-9528 | 17. INFORMANT ADDRESS: Deer's Head Center Records |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | carcinoma of uterus with metastases | 1969 |
| DUE TO, OR AS A CONSEQUENCE OF | with Cobalt and radium therapy | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1829

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that ☒ (this hospital) attended the deceased from July 15, 19 75, to November 28, 19 75, that ☒ (I) (we) last saw the deceased alive on November 28, 19 75, and that in ☒ (my) (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (I) (we) (did) ~~did not~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: H. Wilberg | DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ | 22c. DATE SIGNED: 11-28-75 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. Wilberg, M.D. | 22e. ADDRESS: Deer's Head Center, Salisbury, Maryland | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/7/75 | 23c. NAME OF CEMETERY OR CREMATORY: Dunn Cem | 23d. LOCATION CITY OR TOWN: Salisbury | COUNTY: Wico — STATE: Md |
| 24. FUNERAL DIRECTOR NAME: Russell Foster | ADDRESS: Shumpton Funeral Home | 25a. DATE REC'D. BY REGISTRAR: DEC 03 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jackson Hardin | REGISTRAR |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28324

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Emory | Middle: James | Lost: Taylor | 2a. DATE OF DEATH Month: November | Day: 12 | Year: 1975 | 2b. HOUR: 2:30 PM |
| 3. SEX: Male | 4. RACE: Caucasion | 5. DATE OF BIRTH: 6-18-19 | 6. AGE (In years last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CONSTRUCTION | 12b. KIND OF BUSINESS OR INDUSTRY: Holly FARMS | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: VA | 13b. COUNTY: Accomac | 13c. CITY OR TOWN: Bloxom | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: — | | |
| 14. FATHER'S NAME First: Oris | Middle: Thomas | Lost: Taylor | 15. MOTHER'S MAIDEN NAME First: Flora | Middle: Elsie | Lost: Taylor | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 224-28-6325 | 17. INFORMANT Address: Wife- Ida May Taylor. Bloxom, VA. R.F.D. | | | |

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Spontaneous subarachnoid hemorrhage of

DUE TO, OR AS A CONSEQUENCE OF vertebral aneurysm.

Conditions, if any, which gove rise to immediate couse (a), stating the underlying couse lost. 4309

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c) Recurrence of hemorrhage

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** thot (I) (this hospitol) attended the deceased from 10-23, 19 75, to 11-12-75 19___, that (I) (we) last sow the deceosed olive on 11-12-75 19___, and thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the causes stated above, (I) (we) (did) (did nat) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: H. K. Shoemaker | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 11-14-75 | |
| 22d. PHYSICIAN'S NAME (Type): H. K. Shoemaker, M.D. | 22e. ADDRESS: Medical Center Salisbury MD 21801 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE: 11/18/75 | 23c. NAME OF CEMETERY OR CREMATORY: Liberty | 23d. LOCATION (City or Town): Parksley, | (County): Acc. (State): VA. |
| 24. FUNERAL DIRECTOR: Bellamy D. Holland II | ADDRESS: Accomac, Va. | 25a. REC'D BY REGISTRAR DATE: DEC 09 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jean Martin ACTING REGISTRAR | |

DHMH-16 1/71 30M
(VR A15 (4))

1

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28325

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Erma Middle: P. Last: TAYLOR | 2a. DATE OF DEATH Month: NOVEMBER Day: 2 Year: 1975 | 2b. HOUR 10 30 A.M. | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: May 5 1895 | 6. AGE (In years last birthday) 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico |
| 10. CITY OR TOWN OF DEATH: Salisbury, Md. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Worcester | 13c. CITY OR TOWN: Snow Hill | 13d. INSIDE CITY LIMITS? YES ☑ NO ☐ |
| 13e. STREET AND NUMBER: 309 Park Row | | | |
| 14. FATHER'S NAME First: John Middle: Last: Pruitt | 15. MOTHER'S MAIDEN NAME First: Cornelia Middle: Lost: Corneal | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217072860 | 17. INFORMANT Address: Mrs. Mildred E. Roberts, Perry Hall, Md. | |

80 35 230 2

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Miocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

4109

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pancreatitis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: none | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

2 X

22a. I certify that (I) (this hospital) attended the deceased from 17 oct, 1975, to 2 nov, 1975, that (I) (we) last saw the deceased alive on 2 nov 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Andrew Forgash — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. DATE SIGNED: 5 Nov 75

22d. PHYSICIAN'S NAME (Type): Andrew FORGASH, M.D.

22e. ADDRESS: MEDICAL CENTER, Salisbury

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 11-5-75 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Bates Methodist | 23d. LOCATION (City or Town) (County) (State): Snow Hill Maryland |
| 24. FUNERAL DIRECTOR: Norman F. Hennis | ADDRESS: Snow Hill Md. | 25a. REC'D BY REGISTRAR DATE: NOV 10 1975 | 25b. REGISTRAR'S SIGNATURE: Anne Jan Martin |

RP

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M (VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28326

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JOHN | MIDDLE: -- | LAST: TESTA | 2a. DATE OF DEATH MONTH DAY YEAR: November 16, 1975 |
| 2b. HOUR: M | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: April 16, 1910 | 6. AGE (IN YEARS LAST BIRTHDAY): 65 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Owner | 12b. KIND OF BUSINESS OR INDUSTRY: Restaurant |

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Florida | Palm Beach | Jupiter | YES ☐ NO X | 3410 Harbor Road S. |

| 14. FATHER'S NAME FIRST / MIDDLE / LAST | 15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST |
|---|---|
| Pietro / / Testa | Frances / / Barranco |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (wife) ADDRESS |
|---|---|---|---|
| No | | 213-22-9880 | Mrs. Eugenia K. Testa same as 13 |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma of lung with | 6 mos. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | cerebral metastasis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | YES ☐ NO ☐ | YES ☐ NO ☐ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |
|---|---|---|
| X | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 11/2 19 75 to 11/16 19 75, that (I) (we) last saw the deceased alive on 11/15 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (~~We~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYSICIAN X / MEDICAL DIRECTOR ☐ / STAFF PHYSICIAN ☐ | 22c. DATE SIGNED |
|---|---|---|---|
| Dr. E. M. Beardsley | MD | | 11/17/75 |

| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | 22e. ADDRESS |
|---|---|
| Dr. E. M. Beardsley | Salisbury, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| Burial | 11/19/75 | Wicomico Memorial Park | Salisbury, Wicomico, Maryland |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | NOV 20 1975 | Thomas Jan Martin ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4)) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28327

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH 16 (COM 1/73)
(VR A 15 (4))

1. DECEASED NAME (TYPE OR PRINT): FIRST Alice MIDDLE EMMA LAST TINGLE
2a. DATE OF DEATH: MONTH November DAY 28 YEAR 1975
2b. HOUR: M
3. SEX: F
4. RACE: NEGRO
5. DATE OF BIRTH: MONTH 10 DAY 7 YEAR 1892
6. AGE (IN YEARS LAST BIRTHDAY): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Somerset Co.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Domestic
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md.
13b. COUNTY: Worcester
13c. CITY OR TOWN: Berlin
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET ADDRESS: R # 2 Box 638

14. FATHER'S NAME: FIRST Lloyd MIDDLE LAST Taylor
15. MOTHER'S MAIDEN NAME: FIRST Elizabeth MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN):
16b. IF YES, GIVE WAR OR DATES:
16b. SOCIAL SECURITY NO.: 217-03-5906
17. INFORMANT: James Dennis ADDRESS: 212 Hendrickson Ave. Phila. PA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unk. / yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/10 19 25 to 11/28 19 25, that (I) (we) last saw the deceased alive on 10/28 19 25, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I)(we) (did) (did not) view the body after death.
22b. SIGNATURE: Earl M. Beardsley DEGREE MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]
22c. DATE SIGNED: 11/29/75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Earl M. Beardsley
22e. ADDRESS: U.S. 50at Civic Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 12-6-75
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION CITY OR TOWN: Berlin COUNTY: Worc STATE: Md.

24. FUNERAL DIRECTOR NAME: Jolley Memorial Chapel - Salisbury, Md
25a. DATE REC'D. BY REGISTRAR: DEC 09 1975
25b. REGISTRAR'S SIGNATURE: Thomas James Marden ACTING REGISTRAR

75-28321

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28328

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

| | | | |
|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: James MIDDLE: N. LAST: TOMPKINS | | | 2a. DATE OF DEATH MONTH DAY YEAR: 11. 26. 75 — 2b. HOUR: 6:35 PM |
| 3. SEX: Male | 4. RACE: Negro | 5. DATE OF BIRTH MONTH DAY YEAR: Nov. 27 1906 | 6. AGE (IN YEARS LAST BIRTHDAY): 68 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☑ | 9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD. |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center | 12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Taxi Driver | 12b. KIND OF BUSINESS OR INDUSTRY: Taxi Driving |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Somerset | 13c. CITY OR TOWN: Marion Station | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET ADDRESS: R.1 Box 78 |
| 14. FATHER'S NAME FIRST: Mason MIDDLE: LAST: Tompkins | | 15. MOTHER'S MAIDEN NAME FIRST: Susan MIDDLE: LAST: Wells | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Unknown — (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 218-09-3328A | 17. INFORMANT — ADDRESS: Deer's Head Center Records, Salisbury, Md. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vase. Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mon.
DUE TO, OR AS A CONSEQUENCE OF (b): Arterio sclerotic C.V. Disease — yes.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from Nov. 17, 1975, to Nov. 26, 1975, that (I) (we) last saw the deceased alive on Nov. 26, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE: Lee L Lawry M.D. — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 11. 26. 75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Lee L. Lawry, M.D. — 22e. ADDRESS: Deer's Head Center, Salisbury, Md.

| | | | |
|---|---|---|---|
| 23a. BURIAL, ~~CREMATION, REMOVAL~~ (SPECIFY): Burial | 23b. DATE: 12/1/75 | 23c. NAME OF CEMETERY ~~OR CREMATORY~~: Family | 23d. LOCATION CITY OR TOWN: Marion Sta. — COUNTY: Som. — STATE: Md. |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: Charles H. Ward - Marion Sta., Md. 21838 | 25a. DATE REC'D. BY REGISTRAR: DEC 01 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jan Marthen — ACTING REGISTRAR | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28329

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1. DECEASED NAME (TYPE OR PRINT): FIRST May MIDDLE Riggin LAST Venables
2a. DATE OF DEATH: MONTH 11 DAY 20 YEAR 75
2b. HOUR 2 30 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 4 DAY 9 YEAR 94
6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MaryLand
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Health care Center of Salisbury
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired bookkeeper Bank
12b. KIND OF BUSINESS OR INDUSTRY:

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 220 N Division St

14. FATHER'S NAME: FIRST JACOB MIDDLE LAST Riggin
15. MOTHER'S MAIDEN NAME: FIRST Jennie MIDDLE LAST
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No (IF YES, GIVE WAR OR DATES): —
16b. SOCIAL SECURITY NO.: 214-10-6217
17. INFORMANT: Wm. R. Holloway ADDRESS: 716 Fenndale Rd., Salisbury, Md 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
4339
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (~~this hospital~~) attended the deceased from Oct 24, 19 75, to Nov. 20, 19 75, that (I) (~~saw~~) last saw the deceased alive on Nov 20, 19 75, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Thomas C Hill Jr DEGREE: MD ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED: 11-21-75
22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr Thomas C. Hill, Jr
22e. ADDRESS: Pine Bluff Rd, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11/22/1975
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION CITY OR TOWN: Salisbury COUNTY: Wic STATE: Md.

24. FUNERAL DIRECTOR NAME AND ADDRESS: Hill-Baker-Bounds, Salisbury, Md.
25a. DATE REC'D. BY REGISTRAR: NOV 25 1975
25b. REGISTRAR'S SIGNATURE: Thomas Jan Matthew ACTING REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 1660M 1/75
(VR A 15 (4))

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28330

1

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| EDWARD | MELVIN | Ward | November 8 1975 | 8:35 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | MAY 4, 1903 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | U.S.A. | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hsp. | RETIRED | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | SOMERSET CO | WESTOVER | | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | WARD | EDITH | | HUFFMAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| NO | | | FRANCES WARD WESTOVER, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Respiratory Arrest | MINS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chronic Renal Failure | MONTHS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Arteriolar Nephrosclerosis | YRS. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 403X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Mitral Regurgitation

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from 10/23, 19 75, to 11/8, 19 75, that (I) (we) last saw the deceased alive on 11/8 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Donald M. Wood | MD | ☒ | ☐ | ☐ | 11/5/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DONALD M. WOOD | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | II/II/1975 | ST. ANDREW CEMETERY | PRINCESS ANNE, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| LEVIN R. WILSON | PRINCESS ANNE, MD. | NOV 13 1975 | ACTING REGISTRAR |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

Item#8 filmg490 12/9/75 sy

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28331

1

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2o. DATE OF DEATH Month Doy Yeor | 2b. HOUR |
|---|---|---|---|---|
| KATHERINE | C. | WATSON | 11 25 75 | 5 55 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In yeors last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | CAUC | 3-23-11 | 64 YRS. | | |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| USA | USA | | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Peninsula General Hospital | HOUSEWIFE | — |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | WOR. | SNOW HILL | YES ☒ NO ☐ | |

| 14. FATHER'S NAME First Middle Lost | 15. MOTHER'S MAIDEN NAME First Middle Lost |
|---|---|
| EDWARD L. COFFIN | ALICE KRILL |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No No | | MRS. ELIZABETH ENGLISH BERLIN MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (o) | Acute Myocardial Infarct | MINS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Atherosclerotic Cardiovascular Disease | YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (o), stoting the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

Peripheral Vascular Disease

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospitol) ottended the deceosed from [illegible], 19 [illegible], to 11/25, 19 75, that (I) (we) last sow the deceosed olive on 11/25 19 75, ond that in (my) (our) opinion deoth occurred on the date ond haur ond from the causes stated abave (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Arnold M. Wood | MD | | | | 11/25/75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Arnold M. Wood | Peninsula General Hosp |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| | 11/28/75 | SILVER BROOK | WILMINGTON DEL |

| 24. FUNERAL DIRECTOR ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Anna A. Burbage Berlin Md | DEC 02 1975 | Thomas Jan Martin ACTING REGISTRAR |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

DHMH-16 1/71 30M
(VR A15 (4))

12-50331

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28332

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 (VR A15 (4)) 30M

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: WILLIAM | Middle: F. | Lost: Weidema | 2a. DATE OF DEATH Month: November | Day: 6 | Year: 75 |
| 2b. HOUR | 3:25 AM | | | | | |
| 3. SEX | male | 4. RACE | white | 5. DATE OF BIRTH | Jan. 10, 1896 | 6. AGE (In years last birthday) 79 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | Minnesota | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH: Wicomico Md. |
| 10. CITY OR TOWN OF DEATH | Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Farmer | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Somerset | 13c. CITY OR TOWN | Westover | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER | Rural | | | | | |
| 14. FATHER'S NAME First | Frank | Middle: John | Lost: Weidema | 15. MOTHER'S MAIDEN NAME First | Gotske | Middle: Kemp Lost: Ruddema |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | no | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | 215-36-2292 | 17. INFORMANT: Leon Weidema Address: 1311 Dorchester Ave. Pocomoke City, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town / County / State |

22a. I certify that (I) (this hospital) attended the deceased from Oct. 23, 1975, to Nov. 6, 1975, that (I) ~~(we)~~ last saw the deceased alive on Nov. 5, 1975, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: R. A. Wenrich | DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type): R. A. WENRICH | 22e. ADDRESS: KAY AVE. SALISBURY Md. 21801 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Nov. 8, 1975 | 23c. NAME OF CEMETERY OR CREMATORY: Pitts Creek Pres. Cem. | 23d. LOCATION (City or Town): Pocomoke | (County) Worcester (State) Md. |
| 24. FUNERAL DIRECTOR: Henry H. Watson | ADDRESS: Pocomoke City, Md. | 25a. RECD. BY REGISTRAR DATE: NOV 12 1975 | 25b. REGISTRAR'S SIGNATURE: Anne Jean Martin ACTING REGISTRAR | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28333

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: JOSEPH | MIDDLE: ---- | LAST: WELDON | 2a. DATE OF DEATH MONTH DAY YEAR: November 30, 1975 | 2b. HOUR: M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: April 2, 1889 | 6. AGE (IN YEARS LAST BIRTHDAY): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Wisconsin | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Salisbury Nursing Home | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Machinist | 12b. KIND OF BUSINESS OR INDUSTRY: Forge Company | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: N. J. | 13b. COUNTY: Camden | 13c. CITY OR TOWN: W. Collinswood | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET ADDRESS: 1306 Collins Ave. | | |
| 14. FATHER'S NAME FIRST: (unknown) | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST: (unknown) | MIDDLE | LAST | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 150-10-4519 | 17. INFORMANT: (daughter) | ADDRESS: Box 560 Mrs. Paul Reynolds, R.D. 1, Eden, Maryland | | |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4339 IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Wk.
DUE TO, OR AS A CONSEQUENCE OF (b) Senile & Arteriosclerosis — 4yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Prev. Strokes & left-hemi plegia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11/4, 19 75, to 12/1, 19 75, that (I) (we) last saw the deceased alive on 11/30, 19 75, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Edw Reynolds — DEGREE: MD — ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 12/1/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. E. M. Beardsley — 22e. ADDRESS: Salisbury, Maryland

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 12/3/75 | 23c. NAME OF CEMETERY OR CREMATORY: Calvery Cemetery | 23d. LOCATION CITY OR TOWN: Camden COUNTY: Co., STATE: N. J. | |
| 24. FUNERAL DIRECTOR NAME AND ADDRESS: J. HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | 25a. DATE REC'D. BY REGISTRAR: DEC 04 1975 | 25b. REGISTRAR'S SIGNATURE: Thomas Jean Matthews ACTING REGISTRAR | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28334

1. DECEASED NAME (TYPE OR PRINT) — FIRST: WILLIE — MIDDLE: — LAST: WELLES, JR.

2a. DATE OF DEATH — KNOWN [X] ESTIMATED [ ] — MONTH 11 DAY 23 YEAR 19 75

2b. HOUR 9:32 A.M.

3. SEX: Male

4. RACE: AA

5. DATE OF BIRTH — MONTH 8 DAY 18 YEAR 27

6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. — IF UNDER 1 YR. MONTHS DAYS — IF UNDER 24 HRS. HOURS MIN.

2c. DATE PRONOUNCED DEAD — MONTH 11 DAY 23 YEAR 19 75

2d. HOUR 9:32 A.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Georgia

7b. CITIZEN OF WHAT COUNTRY?: U.S.A.

8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): DOA Peninsula General

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Labor Work

12b. KIND OF BUSINESS OR INDUSTRY: Nursery

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Md.

13b. COUNTY: Somerset

13c. CITY OR TOWN: Princess Anne

13d. INSIDE CITY LIMITS? YES [ ] NO [ ]

13e. STREET ADDRESS: Rogers Labor Camp P.O. Box 321, Princess Anne

14. FATHER'S NAME — FIRST MIDDLE LAST: unknown

15. MOTHER'S MAIDEN NAME — FIRST MIDDLE LAST: unknown

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): unk (IF YES, GIVE WAR OR DATES): unk

16b. SOCIAL SECURITY NO.: unk

17. INFORMANT: Willie Rogers — ADDRESS: P.O. Box 321 Princess Anne

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

4319 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

IMMEDIATE CAUSE (a): Cerebral Hemorrhage, Spontaneous

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ].

ACTUAL SIGNATURE: Earl L. Royer

TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER

DATE SIGNED 11-25-75

EXAMINER'S NAME (TYPE OR PRINT): Earl L. Royer, M.D.

ADDRESS: 409 Camden Ave., Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 11-27-1975

23c. NAME OF CEMETERY OR CREMATORY: House of Jacob

23d. LOCATION CITY OR TOWN: Quantico COUNTY: Somerset STATE: Md

24. FUNERAL DIRECTOR NAME: James Funeral Home, Princess Anne, Md. ADDRESS: Rt. 3

25a. DATE REC'D. BY REGISTRAR: DEC 02 1975

25b. REGISTRAR'S SIGNATURE: Diane Jean Martin ACTING REGISTRAR

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH-17 20M-1-73
(VR A15 ME 15)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28335

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (Type or print) | First: DAVID | Middle: L. | Last: WHEATLEY | 2a. DATE OF DEATH Month: NOVEMBER Day: 25 Year: 1975 | 2b. HOUR: 9:30 A.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 8-18-96 | 6. AGE (In years last birthday): 79 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Wicomico Md. | | |
| 10. CITY OR TOWN OF DEATH: Salisbury | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hsp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER | 12b. KIND OF BUSINESS OR INDUSTRY: AGRIC. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD | 13b. COUNTY: DOR | 13c. CITY OR TOWN: GALESTOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | 13e. STREET AND NUMBER: RFD 3 | |
| 14. FATHER'S NAME First: JOHN Middle: T. Last: WHEATLEY | | 15. MOTHER'S MAIDEN NAME First: CELIA Middle: VICKERS Last: | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 213-22-9015 | 17. INFORMANT: MATILDA E. WHEATLEY | Address: GALESTOWN | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia — 486X
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Leukemia, Acute (? Reticulo Endotheliosis)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from Nov 14, 19 75, to Nov 25, 19 75, thot (I) (~~we~~) last sow the deceased olive on Nov 25 19 75, and thot in (my) (~~our~~) opinion deoth occurred an the dote and haur and fram the couses stoted above, (I) (~~we~~) (did) (~~did not~~) view the body after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Thomas C Hill Jr | MD | ☒ | ☐ | ☐ | 11-25-75 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| THOMAS C. HILL JR MD | Pine Bluff Road, Salisbury, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| BURIAL | 11-27-75 | GALESTOWN | GALESTOWN, | DOR. | MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| ULLRICH FUNERAL HOME | SHARPTOWN MD. | DEC 02 1975 | ACTING REGISTRAR |

DHMH-16 11/73 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
# CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 75-28336

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST: LOLA | MIDDLE: VICTORIA (Cramer) | LAST: WILLEY | 2a. DATE OF DEATH MONTH DAY YEAR: November 6, 1975 | 2b. HOUR: M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH MONTH DAY YEAR: Sept. 30, 1890 | 6. AGE (IN YEARS LAST BIRTHDAY): 85 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: United States | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO MD. | | |
| 10. CITY OR TOWN OF DEATH: Fruitland | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): 608 Clyde Ave. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland | 13b. COUNTY: Wicomico | 13c. CITY OR TOWN: Fruitland | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS: 608 Clyde Ave. | |
| 14. FATHER'S NAME FIRST: Joseph | MIDDLE: Henry | LAST: Smith | 15. MOTHER'S MAIDEN NAME FIRST: Emma | MIDDLE: Florence | LAST: Brittingham |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No | (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO.: 214-10-7332A | 17. INFORMANT ADDRESS: Mrs. Eva M. Coulson (Daughter) same as 13 | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cardiovascular renal disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

404

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE | |

22a. I certify that (I) (this hospital) attended the deceased from 11-4, 1975, to 11-7, 1975, that (I) (we) last saw the deceased alive on 11-4-75, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Philip A. Insley M.D. DEGREE: ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ — 22c. DATE SIGNED: 11/7/75

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Dr. Philip A. Insley, Sr. — 22e. ADDRESS: 116 E. Main St., Salisbury, Maryland

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial | 23b. DATE: 11/10/75 | 23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery | 23d. LOCATION CITY OR TOWN: R.D., Salisbury COUNTY: Wic., STATE: Md. |

| | | |
|---|---|---|
| 24. FUNERAL DIRECTOR NAME / ADDRESS: HOLLOWAY FUNERAL HOME, Salisbury, Maryland | 25a. DATE REC'D. BY REGISTRAR: NOV 12 1975 | 25b. REGISTRAR'S SIGNATURE: Diane Joan Matthew (DEPUTY REGISTRAR) |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 25M
(VR A 15 (4) ) 9/74

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

75-28337

1

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Graydon | | Wilson | November 11, 1975 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| male | white | Sept. 11, 1894 | 81 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Wicomico Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Salisbury | Salisbury Nursing Home Waterman | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Somerset | Crisfield | YES [ ] NO [X] | Rt. 1, Box 116 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Oliver | | Wilson | Lee | | Tawes |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| yes | War 1 | 216-07-7010 | Mrs. Dorothy Wilson, | Rt. 1, Box 116 Crisfield, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hrs.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ] | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 5/14, 1923, to 11/11, 1975, that (I) (we) last saw the deceased alive on 11/10, 1975, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Sally Handley MD DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 11/13/75

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Nov. 14, 1975 | Sunnyridge Cemetery | Crisfield, Somerset, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James L Dennis | Crisfield, Md. | NOV 19 1975 | Thomas Jean Marston ACTING REGISTRAR |

1

# STATE OF MARYLAND
## DEPARTMENT OF HEALTH AND MENTAL HYGIENE
## CERTIFICATE OF DEATH

75-28338

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First IDELLA Middle M Last Woodard
2a. DATE OF DEATH: Month November Day 20 Year 1975
2b. HOUR: 4:48 A.M.
3. SEX: Female
4. RACE: A.A.
5. DATE OF BIRTH: 7-7-1910
6. AGE (In years last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): NO. CAROLINA
7b. CITIZEN OF WHAT COUNTRY? N.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Domestic
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: WIC. COUNTY
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 512 WICOMICO ST
14. FATHER'S NAME: First JOE Middle Last JONES
15. MOTHER'S MAIDEN NAME: First SYLVIA Middle Last SMITH
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16b. SOCIAL SECURITY NO.: 214-12-5305
17. INFORMANT: Address: ARTHUR WOODARD - Salisbury

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CA Cervix c̄ METASTASIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos
180X
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
21d. INJURY OCCURRED: While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION: Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: James P. Gallagher, M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 11-25-75
23c. NAME OF CEMETERY OR CREMATORY: Green Acres Memorial Pk
23d. LOCATION (City or Town) (County) (State): Salisbury Wicomico Md
24. FUNERAL DIRECTOR: West Funeral Home — ADDRESS
25a. REC'D BY REGISTRAR: NOV 26 1975 — DATE
25b. REGISTRAR'S SIGNATURE: Jennie Jean Martin — ACTING REGISTRAR

DHMH-16 1/71 30M (VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR

REG. NO. 75-28339

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST | MIDDLE | LAST | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ MONTH | DAY | YEAR | 2b. HOUR |
| FRANCIS | W. | ZANG | 11 | 14 | 75 | 11:45 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH / DAY / YEAR | 6. AGE (IN YEARS LAST BIRTHDAY) | IF UNDER 1 YR. MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. | 2c. DATE PRONOUNCED DEAD MONTH / DAY / YEAR | 2d. HOUR |
| Male | White | 6 / 3 / 38 | 37 YRS. | | | 11-14-75 | 11 M |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| MARYLAND | U.S.A. | | Wicomico | | | | MD. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Salisbury | Peninsula General | BOAT PILOT | FISHING | | | | |

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET ADDRESS |
|---|---|---|---|---|
| Md. | Worcester | Berlin | | Rt. 2, Box 556 |

| 14. FATHER'S NAME FIRST | MIDDLE | LAST | 15. MOTHER'S MAIDEN NAME FIRST | MIDDLE | LAST |
|---|---|---|---|---|---|
| FRANCIS | J. | ZANG | TERESA | A. | SCHMITT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 216-34-6416 | MRS. J.J. Popp | BERLIN MD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Tension Pneumothorax, Left — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Fracture of Base of Skull — minutes

DUE TO, OR AS A CONSEQUENCE OF

(c)

8121

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M./P.M. MONTH DAY YEAR | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
|---|---|---|
| | 11:27 P.M. 11-14-75 | Passenger in auto involved in collision. |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE |
|---|---|---|
| | intersection, | Rt. 50 & Philip Morris Dr., Wicomico Salisbury Md. |

22a. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE [signature] M.D. TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 11-17-75

EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. ADDRESS 409 Camden Ave., Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION CITY OR TOWN / COUNTY / STATE |
|---|---|---|---|
| BURIAL | 11/17/75 | SUNSET MEMORIAL | BERLIN Wor. MD |

| 24. FUNERAL DIRECTOR NAME / ADDRESS | 25a. DATE REC'D. BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Burbage Funeral Home, Berlin, Md. | NOV 21 1975 | [signature] ACTING REGISTRAR |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM DH 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17 20M 1/73 (VR A15 ME (5))